THE NORTH SHORE SUBSTANCE ABUSE TASK FORCE: AN ASSESSMENT OF DRUG POLICY MAKING AND PRACTICE THROUGH PARTNERSHIPS

by

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RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF URBAN STUDIES

In the Urban Studies Program

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SIMON FRASER UNIVERSITY
Fall 2010

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ABSTRACT

Cities around the world increasingly need to address problems associated with substance abuse. Homelessness, urban decay and neighbourhood unrest are often a result of the critical impacts that substance abuse can have on cities. How cities respond, together with non profit partners and other levels of government is the focus of this research paper. Specifically, the drug policy making practices of the North Shore in British Columbia will be explored. An analysis of the secondary data related to the North Shore Substance Abuse Task Force as well as interviews with key members of the task force reveals how the North Shore went about developing a partnership framework to address substance abuse. This paper concludes that, while looking to other municipalities to model drug policy making is interesting and working on a partnership based approach is beneficial, the importance of embedding an implementation plan directly in the policy cannot be overlooked.

Keywords: Drug policy; partnerships; policy transfer.
ACKNOWLEDGEMENTS

I would like to thank the faculty and staff as well as the students in the SFU Urban Studies Program for creating a stimulating and enjoyable place to learn about cities. I’d like to specifically thank my supervisor, Dr. Meg Holden for her considerable knowledge and well thought out advice during the course of this project and for her patient approach to the research and writing challenges I faced.

I would also like to thank my committee members, Dr. Peter Hall and Dr. Eugene McCann, who provided great insight and commentary on this project.

Special thanks go to my mom, who continues to be an inspiration to me each and every day.
# TABLE OF CONTENTS

Approval .......................................................... ii
Abstract .................................................................. iii
Acknowledgements ............................................... iv
Table of Contents .................................................. v
List of Tables ........................................................ vii
Glossary ................................................................. viii

Introduction ................................................................- 1
Problem Statement: ................................................ 2

Literature Review ..................................................... 6

Methodology: .......................................................... 30
Secondary Research ................................................ 31
Qualitative Research: Key Informant Interviews .......... 31
Analysis ................................................................. 33
Research Limitations ............................................... 34

The Policy Context .................................................... 36
Demographic Profile ................................................ 36
Substance Abuse on the North Shore .......................... 37
Role of the First Nations .......................................... 40
Case Study: The Emergence of the Task Force .............. 41

Part I – LMMA .......................................................... 41
Part II – Development of the Strategy ......................... 46
Part III – Priority Setting and Implementation .............. 51

Analysis .................................................................. 62
Introduction: ............................................................ 62

Partnership Framework: ......................................... 65
Funding for the administration of the partnership .......... 66
Based on need ......................................................... 72
Supports are in place via dedicated staff ....................... 77
That there is active leadership ................................... 81
A focus on resolving conflict and consensus building ..... 83
Good sharing of both knowledge and information .......... 86
Institutionalizing networks so that relationships continue irrespective of people that may come and go .......................... 90
Accountability of all partners for their decisions and actions........................................... 93

Conclusions and Areas for Further Research................................................................. 95
  Funding for the Administration of the Partnership....................................................... 96
  Based on Need ............................................................................................................. 98
  Supports are in place with dedicated staff ................................................................. 100
  Active leadership ......................................................................................................... 102
  Focus on resolving conflict and consensus building .................................................. 104
  Sharing of both knowledge and information ............................................................. 107
  Institutionalizing networks ......................................................................................... 109
  Accountability ........................................................................................................... 111
  Representation ........................................................................................................... 112
  Policy Transfer ........................................................................................................... 113
  Current Status ............................................................................................................ 115
  Further Research ....................................................................................................... 117

Reference List ................................................................................................................. 120

Appendix ......................................................................................................................... 122
LIST OF TABLES

Table 1: Summary table of other collaborative planning work done by the North Shore municipalities: .................................................................................................................. - 9 -

Table 2. Summary timeline and work plan for the SATF.............................................. - 68 -
GLOSSARY

LMMA  Lower Mainland Municipal Association

NS    North Shore (includes the District of North Vancouver, the City of North Vancouver, the District of West Vancouver, Lions Bay and Bowen Island

SAS    Substance Abuse Strategy

SATF   Substance Abuse Task Force

VCH    Vancouver Coastal Health
Introduction

This research project will examine how the five municipalities that make up the North Shore (which includes the District of North Vancouver, the District of West Vancouver, the City of North Vancouver, Bowen Island and Lions Bay) partnered together and created a network of key stakeholders to develop a policy to address substance abuse in their community. The North Shore strategy is similar to other ‘four pillar’ models found in Europe and closer to home, in the City of Vancouver, with a focus on a balanced implementation of prevention, treatment, enforcement and harm reduction services and supports in order to address substance abuse.

This research project will also look at the creation of the North Shore Substance Abuse Strategy (SAS) specifically, with a focus on the important details related to the creation of the task force that was responsible for it, the North Shore Substance Abuse Task Force (SATF and also referred to as the ‘task force’). This will include an examination of the evolution, style, organizational structure and outcomes (i.e. the policy and its implementation) of the SATF partnership. There is no record of how the North Shore came to adopt the SAS, the organizational characteristics of the partnership, whether or not the SAS was successful and finally, what the members felt were the ‘value-added’
characteristics of the partnership. The intent is to examine the motivations of the

The task force, with representation from some of the most powerful political
group, the perceptions of the important features of the task force, the roles and
leaders and decision makers on the North Shore, appeared to have all the
responsibilities as well as the leadership amongst the group in order to better
necessary components to achieve success. However, the governance model
understand how these characteristics of the partnership impacted the
chosen may not have had all the right elements after all because, though the
development and eventual implementation of the SAS.
SATF still exists, whether the implementation of the resulting Substance Abuse
The task force, with representation from some of the most powerful political
Strategy has been successful is less clear. This indicates that perhaps at least
leaders and decision makers on the North Shore, appeared to have all the
parts of the way in which the SATF came together have not been as successful
necessary components to achieve success. However, the governance model
as originally hoped. The focus of this research project is the way in which the
chosen may not have had all the right elements after all because, though the
SATF was originally formulated, the changes that occurred over time and some
parts of the way in which the SATF came together have not been as successful
of the challenges related to the policy’s ultimate implementation.

**Problem Statement:**

As a Social Planner with the District of North Vancouver, I am particularly
interested in the challenges and successes of partnerships such as the SATF
because much of the work that I do with regards to social policy development and
implementation relies on other partners for success. What is also interesting is
the format these partnerships take, what the level of political involvement in the
partnership is and how that affects the successful outcome of the issue the policy is trying to address. As part of the background research done for this project, informal meetings were held with a retired District of North Vancouver Social Planner who was involved with the SATF when it was first created. His comments on the relative importance of this research project are worth noting. He stated that “the making of policy is often over simplified when, in fact, it is a highly complex and contingent process. How a policy came into being may have bearing on whether the policy is understood, accepted and ultimately implemented” (Bostwick, January 2010).

Examining the SAS will provide insight into this complex governance process. There were likely certain turning points or decisions that shaped policy making and policy approval that need further analysis. Developing social policy is complex, involving many stakeholders and partners in an environment that is often politically charged. There is increasing evidence that in this globalized world, local governments, not national governments, have emerged as key leaders in policy making (Sassen, 2005, 2006, Hall 2002). Global cities must respond to the proliferation of critical social issues such as drug addiction and poverty in their midst with policies aimed at mitigating their impact on families and community while at the same time grappling with policies to ensure the economic success of the city itself. Drug policy making is an example of these kinds of efforts.
The North Shore Substance Abuse Task Force

The North Shore’s policy making with regards to drugs provides an interesting example of how municipalities, with other important partners, can organize themselves to try to resolve a complex social issue. Research into other municipalities and regions both locally and internationally reveals that the approach used by the SATF was fairly unique, with five municipalities, two First Nations, two police departments, one health region and two School Districts involved. The diversity of the political partnership amongst all these players is worth examining further. The governance structure adopted by the SATF provides insight into whether or not a task force that is political in nature (as opposed to a grassroots and nonprofit orientated task force) achieves greater success and if so, whether or not it can be replicated.

The SATF provides a useful example of how cities come together to develop policy. There are lessons that can be learned about the unique elements of supports available to the committee, the leadership provided to the task force by bureaucrats and politicians as well as the overall characteristics of the partnership that was created on the North Shore. This type of analysis can provide useful information for municipal staff interested in developing policy across several municipalities and can assist in attempts to maximize the success of similar partnerships that municipalities create to address social policy.
Perhaps the most important and useful information resulting from this research project is the connection between the kind of partnership that is created to develop social policy, in this case drug policy, and the impact of the relative success or failure of the elements of the partnership on the eventual implementation of that policy. While cities can be adept at coming together to address social issues and appear, in the case of the North Shore, to be able to create innovative partnerships to achieve their policy goals, what is particularly difficult is how to turn that social policy into action. This research project will explore a particular kind of partnership developed on the North Shore to address substance abuse and will provide some insight into whether or not that partnership was also able to implement the policy it created. Were there components in the structure of the partnership that affected its ability to implement its goals? What were the effects of similar drug policy making being done by other cities? Did the early days of partnership development even contemplate how the partnership would go about implementing the policy that it would create?

The North Shore Substance Abuse Task Force was a political partnership which consciously excluded the service provider/not for profit sector (though these groups were consulted throughout the development of the policy) in its formal structure. As will be demonstrated in this research project, the not for profit sector was consciously left out of the formal, voting membership of the SATF.
Instead, another committee was established (a community advisory committee) that had no voting ability. While the task force was very successful early on in getting political buy-in and leadership to the table, including First Nations groups, the move from policy writing and adoption to policy implementation has been more challenging. This research project will provide an in-depth analysis and evaluation of the way in which the SATF partnership was formed, which will also provide a context with which to comment on the challenges the task force continues to face to this day regarding the implementation of its substance abuse policy.

**Literature Review**

This literature review will provide a conceptual framework on partnerships that will allow for an analysis of the North Shore’s work on substance abuse policy making and will also provide the parameters with which to analyze the data collected. Included in the discussion around partnerships is an examination of the theory of policy transfer and how that is articulated in the processes and decision making points of the North Shore Substance Abuse Task Force’s drug policy making efforts. The literature review will also provide an overview of the challenges related to policy implementation found in the literature and what specific actions taken by the SATF reveal what may have gone wrong with regards to successful implementation of the drug policy the group created.
It is important to understand that policy transfer is a very practical concept. Simply put, "politicians know what they would like to achieve but the existence of a political majority for a goal is no assurance that politicians will know how to design a process/program to achieve that goal" (Rose, p. ix, 1993). In the case of the North Shore's first attempt at developing a robust drug policy, there appeared to be a general consensus on the way forward, however, the mechanics of making it happen were less clear. It only made sense for politicians and staff to look to other cities, such as their neighbouring municipality, the City of Vancouver, to explore whether existing approaches to municipal drug policy making might also apply to the North Shore. However, before exploring the impact of policy transfer the City of Vancouver may have had on the North Shore's drug policy, it is important to first look at the subtleties of the North Shore itself.

The North Shore is made up of five municipalities: the District of West Vancouver, the City of North Vancouver, the District of North Vancouver, Lions Bay and Bowen Island. Each municipality has a distinct bureaucracy, socio-economic status and political structure. It could be argued that the five municipalities, by agreeing amongst themselves to develop a drug policy collaboratively, were already engaged in policy transfer together. In the case of the North Shore, the precedent had recently been set with the collaborative work done on homelessness policy. The City of North Vancouver originally took a
leadership role on the issue of homelessness, representing the North Shore at Metro Vancouver on the Regional Steering Committee on Homelessness (RSCH). That work prompted a need for that City to encourage the other North Shore municipalities to join together to address homelessness locally (and also to respond in a coordinated way to the funding opportunities that the RSCH would facilitate on behalf of the federally funded Supporting Community Partnership Initiative program). So, the municipal partners worked together with others such as Vancouver Coastal Health, the local service providers dealing front line with homeless such as the Salvation Army and the Harvest Project and others. Their collaborative work on homeless set the ground work for future collaboration on drug policy. In this way, the case to be examined here reinforces the general finding that, “the average public official relies on routines established in the past to guide present actions. Present experience reinforces past experience (Rose, p. 5, 1993)”.

However, of particular interest in this research paper is the way in which the SATF organized itself with regards to non-profit agency involvement around the table. The SATF was different from other partnerships across the North Shore in that it did not formally include the non-profit sector as part of its voting membership. Though these groups were involved in a consultative process in the development of the policy, they did not have any formal ability to make decisions around the SATF table. Other examples of the North Shore’s sharing of policy and related efforts can be found in Table 1.
Table 1: Summary table of other collaborative planning work done by the North Shore municipalities:

<table>
<thead>
<tr>
<th>Policy Examples</th>
<th>Collaborative Planning Features</th>
<th>Partners involved</th>
<th>Date formalized</th>
<th>Shared policy framework?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Core Funding Policy</td>
<td>North Vancouver City and District</td>
<td>1993</td>
<td>Yes. Joint Municipal Youth Policy. Adopted by both municipal Councils</td>
<td></td>
</tr>
<tr>
<td>Together Against Violence Network</td>
<td>North Vancouver City and District, West Vancouver, Vancouver Coastal Health, local Non Profits, the Ministry of Attorney General, Adults at Risk Network</td>
<td>1997</td>
<td>Yes. Zero Tolerance for Violence Policy. Adopted by three North Shore municipalities and all other partners</td>
<td></td>
</tr>
<tr>
<td>North Shore Homelessness Task Force</td>
<td>North Vancouver City and District, West Vancouver, Vancouver Coastal Health, Faith Community, local Non Profits</td>
<td>1998</td>
<td>Yes. Ten Year Homelessness Work Plan (2010-2018). Approved by 3 municipal Councils and all other partners</td>
<td></td>
</tr>
<tr>
<td>Action on Prevention Network</td>
<td>North Vancouver City and District, West Vancouver, Vancouver Coastal Health, local Non Profits, RCMP, West Van Police</td>
<td>2007</td>
<td>Yes. Agreed upon Terms of Reference. Presented to each of the 3 municipal Councils and all other partners</td>
<td></td>
</tr>
<tr>
<td>Childcare Needs Assessment</td>
<td>North Vancouver City and District, West Vancouver, Vancouver Coastal Health, Faith Community, local Non Profits</td>
<td>2008</td>
<td>Yes. Presented to each of the 3 municipal Councils and all other partners</td>
<td></td>
</tr>
<tr>
<td>Multi-Agency Planning Table</td>
<td>North Vancouver City and District, West Vancouver, Vancouver Coastal Health, Ministry of Child and Family Development</td>
<td>2009</td>
<td>Yes (though nothing formal adopted). Agree to work together to make collaborative funding decisions for youth ages 13-18</td>
<td></td>
</tr>
</tbody>
</table>
When it comes to developing policy in a collaborative process, who is involved and more importantly who ‘leads’ are important factors in the success of that process. The following discussion will reveal that there can be differences among members’ perception of the leadership structure and its overall effectiveness. There is debate in the literature about whether partnerships help decision making or leave a vacuum of leadership where different roles and responsibilities are left unclear.

Drug abuse problems in cities reached a crisis point in the 1990’s and policy makers, police and service providers eventually came to the realization that the ‘war on drugs’ approach was not working. New approaches and innovative ways of working together were needed (Wälti and Kübler, 2003). A collaborative planning approach was viewed as a possible solution because it responded to both ideational struggles (i.e. those that felt that addressing drug abuse in the community was required both morally and ethically) and power struggles by giving all actors their share of participation in the process (Healey, 1998). The underlying premise of collaborative planning is that building partnerships across a broad spectrum of community stakeholders is an effective way to grapple with an issue that has the potential to be divisive and polarizing. Drug policy would easily fit into this category as solutions to substance abuse often involve developing infrastructure (e.g. safe injection sites, detox centres) and supports (e.g. day treatment programs, methadone clinics) that can create tensions in communities
whose residents are fearful of living next door to these types of places and programs.

Proponents of collaborative planning would argue that “grassroots mobilization on constantly changing issues become the driving force of urban politics … it is no longer easy to hierarchically manage services because it’s too fractured. Therefore policies need(ed) to be targeted at the heterogeneous urban needs …” (Wälti and Kübler, 2003). A diverse range of people need to be consulted and/or directly involved in the development of a policy, which lends a certain amount of credibility and legitimacy to the planning process and ultimately the decisions that come out of that process (Healey, 1998). Efforts must be made to ensure that everyone is included that needs to be. This is done by ensuring all those community stakeholders as well as agencies and organizations that have substance abuse as parts of their mandate are included. It is important to clarify that those agencies with an organizational mandate to deal with substance abuse may not be the only (or even the most important) partners at the table. For example, those agencies and organizations that don’t specifically have drug and alcohol abuse as part of their mandate may in fact be working with people who are affected by drug and alcohol abuse. Examples include youth outreach workers, whose mandate is to work with at risk youth. Those youth may not have substance abuse problems themselves, but are directly affected because one or both parents do. Another example is school district staff whose mandate is the
K-12 education curriculum but who also work with parents who are dealing with substance abuse issues. So, both stakeholders and those working on the periphery of the substance abuse mandate should be involved as all of them are important players in developing a solution to the complex problem of substance abuse.

Engaging in a collaborative planning approach and building these networks would have a direct impact on the success of a proposed policy. There are pragmatic concerns worth mentioning as well. Working together can help to address obvious areas of concern such as the need to share information and resources, the desire to share costs, particularly for those organizations and municipalities that are too small to take on the work required independently and the ability to share expertise, which larger organizations may have more of than smaller organizations. It is also easier politically to move forward on something such as drug policy when all partners (particularly those concerned with the location of services as far as geography goes such as municipalities) are working together. There is in fact strength in numbers provided by working collaboratively that is critically important to the political palpability of drug policy making.

Kübler and Wälti (2001) conducted research on collaborative planning for substance abuse policy in Swiss cities and discovered that there has been an increasing tendency by cities to work towards establishing networks of
stakeholders in their efforts to plan for and develop policy responses to programs concerned with health and welfare/social issues. Reasons for the focus on health and welfare stems from the huge costs of these types of programs overall (Wälti and Kübler, 2003) for which cities are significantly challenged to pay. The need for cities to respond to drug abuse on their streets created a perfect opportunity to pursue collaborative planning agendas and bring a variety of groups together to work with municipal staff. This tendency of cities to turn to networks and partnerships in order to work collaboratively is also an opportunity for cities to learn from one another.

In the Sustainable Cities: City to City Learning report, cities participated in sharing “their learning and best practice about integrated long-term planning and sustainability demonstration projects” (Seymoar et al, p. 5, 2009). The cities, forty in total, were striving to “create organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free and where people are continually learning to see the whole together” (Seymoar et al, 2009). The authors discuss the benefit of these city to city collaborations and argue that cities are the places where knowledge is created, stored and most importantly, shared with others. The cities act as repositories for knowledge and use the collaborative planning approach to both increase this knowledge (by bringing all the key players and stakeholders to the table) and even more
importantly, to share the knowledge with others in an effort to tackle whatever issues need to be addressed. By doing so, self organizing networks emerged. These self organizing networks, which were simply a diverse group of interested parties coming together to address one issue, were in fact the result of policy makers at the city staff level opening up the process of policy making to other actors in the community in order to enhance the policy making effort. In other words, the “central argument in favour of self organizing networks … is the capacity to enhance responsiveness and quality of public policies by bringing together a wide range of public agencies and private organizations” (Wälti and Kübler, p. 505, 2003). Though this is not the most common kind of collaborative planning, self organizing networks do appear in this case to build the buy-in necessary for success.

However, detractors of collaborative planning provide another point of view. For example, one of the criticisms in the literature of the collaborative planning approach taken by cities in the past two decades is the question of representation (Asthana et al, 2002). Small non profit agencies may have a hard time finding one representative that is able to participate fully in the partnership because of a lack of organizational capacity (both functional capacity and time, which can be difficult to find for a small non profit).
Similarly challenging, the expectation that agencies must come together to work collaboratively may cause some agencies to refuse to participate because of a perceived loss of autonomy and even risk of loss of funding because agencies competing for government grants may end up being asked to work together (the logic that follows is that one agency may then need to give up partial funding to the other for the 'greater good'). The challenges of representation do not only impact small agencies. All potential partners may find themselves in a conflict over whether or not to participate depending on things like a limited interest in the issue or lack of jurisdiction (even lack of *perceived* jurisdiction) over the issue. If the idea is to cooperate fully in the process, how do these networks, partnerships and task forces, achieve full representation? The collaborative planning approaches used by municipal governments may in fact unknowingly exclude key stakeholders. Furthermore, a consensus based model of decision making can inevitably lead to the 'radical voice' being lost or at best co-opted (Asthana et al, 2002), particularly when the goal is to reach consensus in all decision making. It may be true that a consensus is not required and therefore only optional. In the cases where consensus based decision making is optional (for example a vote could pass with a 50% plus one margin), there must a clear understanding by the group at the outset that these are the rules. These can be outlined in a Terms of Reference document at the beginning of any partnership process – and before any decisions are made – in order to avoid any confusion as the partnerships moves forward.
In exploring the North Shore collaborative planning process more specifically, Kübler and Wälti’s research on municipal drug policy creation in European cities provides an excellent overview of the impact drug related problems have had on cities and what types of municipal governance systems were created in order to respond to these problems. They argue that drug issues are debated in cities in terms of the responses available to solve them; on one hand there is the possibility of an economic development approach whereby drug ‘ghettos’ are revitalized (some would argue gentrified) in order to make them more desirable for wealthy tax payers. By getting rid of the drug users, the cities succeed in getting rid of the drug problems. They call this an ‘attractiveness policy’ approach. On the other hand, there is a social service provision approach that responds to drug issues with services, supports and empowerment for those addicted. They call this a ‘social policy’ approach. Kübler and Wälti (2001) describe how the tensions between these two approaches have encouraged a growing number of cities to form specific kinds of partnerships and cooperate to find solutions that are palatable to all the stakeholders involved.

Collaborative planning theory emphasizes the need for cities and planners to work with all to ensure a diversity of opinions are available and that the solutions are comprehensive and successful. This approach, done well, would address the concerns that those critical of partnership approaches may have. Key
stakeholders need not be limited to but can (and many argue should) also include those individuals that abuse drugs as their input can be valuable in developing a robust response to the concerns the policy is attempting to address.

Even though the popularity of applying the collaborative planning approach can be found in the cities explored by researchers such as Kübler and Wälti, the literature on how to evaluate whether or not it’s actually working is more difficult to find. That is to say that “remarkably little is known about how to translate the rhetoric of partnership working into practical reality. Statements about partnerships and collaborative planning tend to be rather normative such as partnership being taken to be a ‘good thing’. Little substantive guidance is given about what is even meant by partnership – let alone conditions or factors that increase the probability of effective partnerships emerging” (Asthana et al, 2002).

In order to be successful, embarking on a partnership model to develop policy to address concerns about drug abuse must prove to be more than just a ‘good thing’. There must be a tangible methodology with which to evaluate the successes and failures of the approach to policy development both at the beginning of the process as well as at various stages throughout the process.

Asthana et al. propose a simple framework for evaluating a successful partnership approach that is useful here. Inputs to the framework include:
1. questions of funding for the administration of the partnership
2. that it be based on need
3. that supports are in place via dedicated staff
4. that there is active leadership
5. a focus on managing conflict if it exists but working toward consensus building
6. good sharing of both knowledge and information
7. institutionalizing networks so that relationships continue irrespective of people that may come and go
8. accountability of all partners for their decisions and actions.

The framework provides this simple check list with which to evaluate partnerships that is practical when looking more closely at the North Shore's work on substance abuse policy. Further discussion on how this framework is applied to this research project can be found in the data analysis section of this paper. However, representativeness appears to be missing from the framework. Asthana et al do not specifically list the need for true representation as a critical feature of their checklist. Though possibly implied in their highlighting of both leadership (i.e. getting the right people and the right leaders around the table) as well as sharing of information and knowledge (i.e. making sure all the key stakeholders both know about and are invested in the process), a particular focus on representativeness may have further strengthened their partnership checklist.

The literature reveals that the “proliferation of local partnerships reflects an ongoing crisis in the traditional statist model of public policy development and
associated demands for more entrepreneurial and inclusive approaches to policy
design and delivery” (Bristow, Entwistle, Hines & Martin, p. 903, 2009). The
move away from a top down approach to policy making to one that focuses on
getting a variety of different groups and actors involved in the decision making
process is seen to be very positive. In fact, a consistent criticism of city’s and
their work on policy development is that they have excluded someone or some
organization from their process. The impact of this kind of criticism can be
severe, causing the whole process of policy making to be called into question
because not all stakeholders were present and accounted for. The ‘buy in’ from
all stakeholders must be ensured otherwise the legitimacy of the whole process
is called into question. The literature also illustrates that the popularity of a
partnership approach to policy making may cause “partnership fatigue, low levels
of community interest and activist burnout” (Bristow, Entwistle, Hines & Martin, p.
904, 2009). Representation can therefore be difficult to attain because those
community stakeholders working in the non profit sector which bring a specific
kind of legitimacy with them often have the least amount of capacity to be able to
meaningfully participate in the variety of partnerships that emerge. They are
often struggling to sustain their funding, are understaffed and must balance
increasing needs with often decreasing dollars to work with.

The question then becomes whether or not diverse representation is truly the
best course of action when embarking on policy making. The literature on
representation provides a compelling argument for indeed working to ensure a representative partnership approach. One of the most basic reasons is that “local governments' policy choices are confined to structural constraints and as a result, local politics is best characterized as limited politics where local government policy agendas are relatively narrow with an almost exclusive focus on enacting policies aimed at improving economic growth” (Percival, Johnson & Neiman, p. 165, 2008). The emergence of partnership approaches to drug policy taken on by cities as diverse as Vancouver, Zurich, Frankfurt and the North Shore illustrates the tension between the need for cities to improve their economic growth while at the same time addressing the social policy issues that have a direct and negative impact on economic growth, things such as substance abuse. The true impact of the non profit sector in policy making cannot be underestimated. The literature of public administration reveals that not only do non profits have a direct, positive effect on partnerships, but those non profits that are actively representative of their clientele (such as VANDU, the Vancouver Area Network of Drug Users for example) are much more likely to be able to move the partnership from policy making to implementation because the policy is consistent with their belief systems and interests (Meier, 1993; Meier & Bonte, 2001; Sowa & Selden, 2003; Wilkins & Keiser, 2006; LeRoux, 2008). They provide legitimacy which is imperative to the eventual successful endorsement and implementation of the policy being created. LeRoux describes these non
profit actors as “civic intermediaries, or structures linking citizen clients to
governing systems and processes” (LeRoux, p. 742, 2008).

When partnerships fail in being diverse with regards to representation, two very
specific problems arise. The first is the overall legitimacy and equity of the
partnership. Bristow, Entwistle, Hines & Martin (2009) argue that many of the
partnerships they reviewed were being led by a very small, and elite group of
people who may have thought that they represented a larger constituency but in
fact they did not. Reasons given as to why these actors would participate often
conclude that the motivation is self interest and that they are acting
opportunistically. The second and equally important concern is the ability for a
partnership to be truly effective in dealing with the issue their policy wants to
resolve. Without a diverse and robustly representative group, the knowledge,
experience and contacts needed to be able to be thorough and comprehensive in
their approach is particularly difficult. The result is that the policy being created is
ineffective, and implementation frustrating to achieve. It is important to note
though that more people on a partnership aren’t necessarily better. It’s not about
the number of representatives on a particular partnership that makes it
successful, it’s about the expertise and knowledge that they, and others bring to
the table that must be realized.

While cities are experimenting with collaborative planning approaches to issues
such as substance abuse, there is also an increasing interest in something called
policy transfer. Drug use and the resulting issues that are caused by drug use in cities are "concerns that lead ordinary people to turn to government – education, safety on the streets, economic prosperity – are common across constituents. Dissatisfaction with government is widespread too. Everywhere policy makers are under pressure to act. Lesson drawing is used as a tool to figure out what to do" (Rose, p 3, 1993).

There are varying views of the feasibility and even of the existence of policy transfer in the literature. There are those researchers who feel strongly that policy transfer theory is a relevant and substantive part of modern planning practice not only in local, but national and even international contexts. They argue that the "relevance of cross national policy transfer promises to increase with advances in communications and the process of globalization" (Mossberger and Wolman, 2003) and that this increase can be traced through case study evidence. Proponents of policy transfer provide the following broad definition: "policy transfer, emulation and lesson drawing all refer to a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another place" (Dolowitz and Marsh, 1996). Put another way, "lesson drawing involves a trial and error search across space and time" (Rose, p.xiv, 1993). With such broad definitions of policy transfer and so
many ways to make a claim that policy transfer did in fact occur, claims that the practice of policy transfer abound (James and Lodge, 2003).

Mossberger and Wolman (2003) would disagree, arguing instead that the notion of policy transfer is nothing more that a new way of describing what has always been called rational policy making. They would argue that the definition is so broad that any kind of policy making could be called policy transfer and furthermore, that no real proof exists that the practice is increasing at all. Though there are growing numbers of case studies exploring theories of policy transfer, they have “yielded little systemic comparison between cases” (Mossberger and Wolman, 2003) and further research is required in order to accurately make claims that something called policy transfer actually exists distinct from regular policy making.

Exploring this logic further, a lesson “requires a cause and effect model showing how a program designed on the basis of experience elsewhere can achieve a desired goal of being adapted in the advocate’s own country” (Rose, p. 13, 1993). However, authors such as Mossberger and Wolman would argue that truly, this is just regular policy making and nothing more.

The North Shore Substance Abuse Task Force met early on with key staff members and politicians at the City of Vancouver to learn about how they
The North Shore Substance Abuse Task Force developed their substance abuse policy entitled *A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver*. The process that Vancouver went through was long and intensely political but the policy was eventually adopted by Vancouver City Council in 2001. Though the relative success or failure of the implementation of Vancouver’s four pillar policy continues to be debated today, the policy itself has become well known and the collaborative planning process used by Vancouver to develop the policy is also generally well respected (McCann, 2008). The North Shore’s interest in Vancouver’s efforts to deal with substance abuse may appear on the surface to be an example of policy transfer but it may not necessarily have been that overt. The idea of ‘borrowing’ policy process and policy development techniques from other places (McCann, 2008) will be explored in this research project, looking specifically at whether the benefits were the legitimacy Vancouver’s success provided to the North Shore or merely the ease with which Vancouver’s best practices could be duplicated on the North Shore.

While the detractors of policy transfer’s overt presence in every day planning processes exist, there is literature that points to specific case studies whereby the concept of policy transfer is, according to them, well documented. Specifically, researchers are interested in the complexities of ‘urban policy mobilities’. That is, how do policies develop in one setting and then get transferred to another? And equally important, who are the ‘policy transfer
agents' or experts in a specific policy field and how do they become viewed as experts while others are not (McCann, 2008)? McCann uses Vancouver's drug policy as a case study to explore how urban policy transfer works. He describes how Vancouver politicians and senior staff (policy transfer agents) traveled to several European cities to learn about their drug policies in the late 1990's. They brought their knowledge back and began formulating their own drug policy. Vancouver's drug policy is now widely known and respected in the field – and has even become known as the "Vancouver Model". McCann stresses that the Vancouver policy makers considered the face to face connection and first hand experience with their European counterparts as critical to the success of their own policy. It can be said that "when is as important as whether in the politics of lesson drawing. Lesson drawing enables policy makers to escape from the tyranny of the present which rejects anything that is not instantly applicable" (Rose, p. 152, 1993). Lesson drawing then is implied as being similar to policy transfer in that policy makers take work from other places and can then more easily make it applicable by the mere fact that it has been done somewhere else and is therefore at least in some place, successful.

An example can be one found in the Sustainable Cities: City to City Learning report. The report, which included a literature review of different types of institutional learning, illustrates how "networks represent a web of connections among equals, not held together by force, obligation, material incentives or social
contracts, but by shared values and the understanding that some tasks can be accomplished together that can never be accomplished separately" (Seymoar et al., 2009). The central concept is that networks are an integral part of both the creation of knowledge and the transfer of knowledge. Furthermore, Seymoar et al. argue that these types of diverse networks are necessary for cities as they work toward creating innovative policy. Of particular interest in this literature review is the concept that cities share information and best practices with each other and that the way in which information is disseminated between them happens primarily through face to face meetings.

Any discussion of policy transfer and partnership making for the purposes of developing policy must speak at least briefly about the efforts to implement the policy that is created. Simply put, "implementation may be viewed as a process of interaction between the setting of goals and the actions geared to achieving them" (Pressman & Wildavsky, p. xxi, 1979). Unfortunately, implementation is never quite as simple as it may appear. Policy is an iterative process, one that changes over time and as members and issues come and go. As illustrated by Asthana et al., the importance of accountability cannot be underestimated. When the membership of a group that set out to develop a policy changes, what happens to the original intent of that policy and the determination to implement that policy? It can be said that "the passage of time wreaks havoc with efforts to maintain tidy distinctions. As circumstances change, goals alter and initial
conditions are subject to slippage" (Pressman & Wildavsky, p. xxi, 1979). By nature policy creation and implementation occurs over time. It is rare that policy creation and implementation are succinct. Over the course of the time taken to develop policy the dreams of implementation may fade or at the very least, change.

Pressman and Wildavsky argue that separating the creation and development of policy from the implementation of policy is a critical error that is frequently made. There is often a sense of urgency and purpose when a group comes together to develop policy, and it is usually based on an issue that they are trying to resolve. However, it is much easier to create a policy response to an issue than it is to detail, as part of that policy, how the issue originally motivating the group will be resolved. The tendency is to leave the problem of implementation to a second phase of policy making or, to another group of individuals tasked with carrying out the original intent of the policy makers. This creates unnecessary layers of bureaucracy and leaves the accountability of the membership, a key component of Asthana et al's partnership framework, to another process and/or group. This all too common approach is eloquently summarized by Pressman and Wildavsky in speaking about a US federal government run work program:

The view from the top is exhilarating. Divorced from problems of implementation, federal bureau heads, leaders of international agencies and prime ministers in poor countries think great thoughts together. But they have trouble imagining the sequence of events that will bring their
ideas to fruition. Other men, they believe, will tread the path once they have so brightly lit the way. Few officials down below where the action is feel able to ask whether there is more than a rhetorical connection between the word and the deed.

Leaving the implementation of policy to officials who don’t know the intent and end goal of that policy doesn’t bode well for success. However, failure in implementing a policy is not always easily explained by assuming that the issues were too complex, the process was too multifaceted or the ultimate goal too lofty. Unfortunately, the reasons are often much more mundane. As indicated above, the passage of time deals a particular blow to policy implementation. Kübler and Wälti articulate the sense of urgency that the Swiss government had in addressing the crisis of drug users in their cities. This sense of urgency was fueled by open drug scenes in city parks and very visible drug abuse and death. However, in cities where drug use was more hidden (i.e. use in private homes rather than on the street for example) this sense of urgency did not exist. The time needed to develop a drug policy, which could take years, could become the worst enemy of implementation. By the time all the partners had adopted the policy, the rationale for doing it in the first place may have been lost to another priority, which could hamper the successful implementation of the original policy. In short, the interests of policy partners are often short lived and the reasons for failure to implement the policy are not that earth shattering. People just move on.
Pressman and Wildavsky do provide a list of "reasons why participants may argue with the substantive ends of a proposal and still oppose (or merely fail to facilitate) the means for effectuating it" (Pressman & Wildavsky, p. 99, 1979).

This list of reasons is:

1. direct incompatibility with other committees
2. no direct incompatibility but a preference for another program
3. simultaneous commitment to other projects
4. dependence on others who lack a sense of urgency in the project
5. differences of opinion on leadership and proper organizational roles
6. legal and procedural differences
7. agreement coupled with lack of power

It is clear that, even with the best of intentions and where both a commitment and a sense of urgency are present, the nature of partnerships imposes challenges on the successful implementation of the policies created by them. Competition with other projects that require time and resources to implement poses problems that have to do not so much with disagreement, but rather the ability of members of the partnership to get the work done while at the same time doing their other projects. Which one gets priority and how does that get decided? Even more challenging, projects requiring implementation may come across differences of opinion on procedures, and on the legalities of the work being implemented. These are even harder to overcome. With no consensus on how to move forward to implementation, implementation invariably gets stalled. The chances that all seven of the reasons for policy implementation failure can be addressed are likely slim.
However, the literature identifies two very important features that can improve the likelihood of success. One is the need to “pay as much attention to the creation of the organizational machinery for executing a program as for launching one” (Pressman and Wildavsky, p. 144, 1979), and the other is “simplicity in policies is much to be desired. The fewer steps involved in carrying out the program, the fewer opportunities for a disaster to overtake it” (Pressman and Wildavsky, p. 144, 1979). The ability to keep the policy simple, to have the right people at the table and to consider implementation as an integral part of the development of policy does much for the potential implementation of that policy. Asthana et al. discuss the specific components of successful partnerships and speak to the need to have accountability, leadership and so on. However, they do not consider the subtleties of the work being done by the partnership and say very little about the need to consider implementation when deciding how to create a successful partnership.

Methodology:

Two primary methods were used throughout this research project to gather the data necessary. The first was key informant interviews with members (past and present) of the SATF and the second was a detailed examination of the secondary data available on the SATF, primarily from the City of North Vancouver. The City of North Vancouver provided administrative support and
oversight for the SATF from 1998 until 2006, therefore most of the documents were located there. The documents from the District of North Vancouver and the District of West Vancouver were minimal and for the most part, duplicates of the master files from the City of North Vancouver.

**Secondary Research**

Research on the North Shore's Substance Abuse Task Force drew on several documentary sources made available primarily through the City of North Vancouver, with other data gathered from the District of North Vancouver. These included:

1. policy documents produced by social planning staff from the three North Shore municipalities
2. staff reports produced by social planning staff from the three North Shore municipalities
3. official minutes of meetings of the SATF as well as meeting notes from meetings that predate the official formation of the SATF
4. consultant Reports, including first and second drafts, of public consultation forums held across the North Shore, in Lions Bay and Bowen Island

**Qualitative Research: Key Informant Interviews**

Interviews were the primary research method used to gather the information necessary for this research project. Six key informants were identified from the data on the SATF as being important in the development of both the governance and structure of the SATF as well as the way in which the policy was crafted early on in the process. While the task force was never more than 15 members, these key informants emerged as key political and professional leaders in the
process of developing the task force and the resulting four pillar substance abuse policy.

Interviews were conducted between April and July 2010. The interviews were semi-structured and varied in length from one to two hours. The initial contact was through an introductory email with the informed consent document attached as well as the interview questions. Interviewees were given the option of first reviewing and filling out the twelve questions on their own time and then meeting for a face to face interview, or providing answers to the questions directly during the interview.

One interviewee emailed his responses directly so no transcribing was necessary. A follow up email helped to clarify a few points that were unclear in the original set of answers. For the remaining five interviewees, notes were taken during the face-to-face interview and were then transcribed verbatim. In two instances interviewees requested that they be given the written transcript of their interview to ensure clarity and accuracy. Of the two that made this request, one had several very minor additions to the written transcript that were incorporated into the final interview transcript.

Once all of the interviews were transcribed, the data was organized and coded based on the eights key characteristics of a partnership framework developed by Asthana, Richardson and Halliday (2002) for further analysis. These are:
1. funding for the administration of the partnership is provided
2. that it is based on need
3. that it has dedicated staff
4. that there is active leadership
5. a focus on conflict and consensus building (that is to say that how a partnership deals with conflict can also be a window in to how they work toward consensus based decision making. Asthana et al see both components as important for the framework)
6. sharing of both knowledge and information (that is to say that the partnership strives to both gather knowledge and information – which is connected to point number two above regarding need - as well as to share it with both the members of the partnership, but more widely as well, with people who are affected by the work of the partnership for example)
7. institutionalized networks
8. accountability of all partners and their decisions and actions

Analysis

Once the secondary data was collected, it was reviewed and notes were made summarizing pertinent comments related to this research project from the proceedings of the SATF since its inception. This included excerpts from minutes, reports, and relevant policy documents. The notes became the basis of the background story for this project, providing some insight into both the mechanics of how the SATF came together, which is an important part of the story as it relates to partnership making, as well as the input of the public and ‘non-partner’ members of the SATF. The background eventually became the policy context for this paper, assisting in filling in the gaps of information not provided by key informants during the interview phase of the project.

The interviews with key informants were an integral component of the project, providing first hand insight into the subtleties of the partnership not revealed in
the secondary data. The information gathered from the membership of the task force also provided personal insight into the relative success of the partnership, which varied depending on which member responded. Once all the comments made by interviewees were organized into the key components of Asthana et al's framework, they were analyzed further and the story of the SATF partnership began to emerge. Key themes in the responses were noted under each of the eight partnership characteristics so that conclusions could be drawn regarding whether or not the SATF was in fact a successful partnership.

Research Limitations

There are several limitations this research project presents that are worth noting. The first and perhaps the most critical, is the time frame of the project. The SATF came together over a decade ago and some of the interviewees had a hard time remembering the details of how the SATF came together as a group. While everyone knew why (and in fact all still considered the work of the SATF important and substance abuse issues as worth addressing in community), the subtleties of the partnership were difficult to remember for some of the interviewees because it all happened so long ago.

The second limitation of the project has to do with the scope. While the story of how the SATF came together to form the specific kind of partnership it did is an interesting story and worth telling, what is more compelling is whether or not the partnership was successful in achieving its goal, in this case the implementation
of the policy it created to address substance abuse in the community.

Unfortunately this project is not big enough in scope to meaningfully get into the full story of the implementation of the SAS however, the key informants did speak to implementation often when considering the questions related to Asthana et al’s partnership framework.

Finally, the last limitation is current context of the SATF. Beginning in 2006, the task force began to struggle with regard to its purpose and effectiveness as a partnership. A work plan was created in 2006 that was in effect for two years, and though it revived the task force somewhat, it did little by way of successful implementation of the SAS. Further work was done with the committee in 2008 but again, there was very limited success in achieving its goals of dealing with the North Shore’s substance abuse issues in an effective manner. This lack of focus and lack of success was top of mind with many interviewees and as a result, many had a hard time remembering (or even wanting to speak really) about the task force in its early days. The drama of today was much more interesting.
The North Shore Substance Abuse Task Force

The Policy Context

Demographic Profile
The North Shore is made up of the District of West Vancouver, the District of North Vancouver, the City of North Vancouver and the Village of Lions Bay and Bowen Island (which receive all of their municipal services such as garbage, planning and recreation from the District of West Vancouver, however police services for Bowen Island are provided by the RCMP not the West Vancouver Police). With a combined population of 187,688 (Statistics Canada 2006), the North Shore is a community situated along the Coastal Mountains and the Pacific Ocean and is directly across Burrard Inlet from the City of Vancouver. Known as the Metro Vancouver region’s most affluent community, the North Shore has some of the most expensive real estate in the Lower Mainland. However, the status of the North Shore as an affluent community and the assumptions that this brings with it of a community without any social issues is deceiving.

The North Shore has many of the same social issues seen in other municipalities, regardless of its overall high levels of prosperity, health and well being. Child poverty rates (as defined by the Stats Canada Low Income Cut Offs) in private households in West Vancouver are 17.5 %, in North Vancouver City the child poverty rate was 19.7%. The province wide rate is 14.9%. In a report entitled “North Shore Community Health Profile 2009”, the impact of

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1 Lions Bay and Bowen Island are included as part of the North Shore for the purposes of this research project.
poverty on families is described and the report states that “the need to reduce child poverty and increase investments that work towards ensuring a healthy start in the early years will reduce the long term costs associated with health care, addictions, crime, unemployment and welfare” (North Shore Community Health Profile, p. 24, 2009). The North Shore has also experienced a significant increase, essentially tripling its homeless population since 2002 when the Regional Steering Committee on Homelessness conducted the region’s first homeless count. The number of homeless individuals on the North Shore in 2002 was 44. By 2005 that number had increased to 83 and by 2008, it had increased again to 123. The link between homelessness and addiction makes this data particularly relevant to this research project.

Substance Abuse on the North Shore

Research for this project revealed surprisingly little statistical information collected by the SATF regarding the incidence and prevalence of substance abuse on the North Shore. A report written in 1991 on substance abuse on the North Shore (which predates the SATF) is often referred to for statistical data on the problem but the information is otherwise anecdotal, coming from substance abuse service providers on the North Shore such as West Coast Alternatives Society and Seaview Addictions Society. A City of North Vancouver Planning report states that:

(Services for) substance abuse on the North Shore found a lack of prevention, treatment and outreach services for youth and young adults. It
also noted that there was a need for a detox facility on the North Shore and for better coordination among service agencies. The report found that alcohol abuse was the greatest concern on the North Shore. ... There is currently a waiting period of two to three months for (drug) counseling on the North Shore due to lack of funding. (Larry Orr, Social Planner, CNV Council Report September 2, 1998, page 2)

While substance abuse issues on the North Shore are not as visible or critical as in places such as the Downtown Eastside (DTES) in the City of Vancouver, the concern task force members had at the beginning stages of their work together was that the social crisis of the DTES must be avoided at all costs and that the community should collectively do as much as was required to address the problems of substance abuse head on. It became one of the strongest rationales in agreeing to work together to address this problem in the community.

Another theme is strong desire to find services for North Shore residents with substance abuse problems on the North Shore, and that there not be an expectation that residents find services elsewhere. Ironically, the DTES was closer to the North Shore than any other Vancouver neighbourhood, just a short seabus ride away from the City of North Vancouver, so there was most certainly a worry that either North Shore residents would be enticed by the open drug scene in the DTES or, that the drug users in the DTES would come to the North Shore. So, the motivation to establish a strong partnership approach to address and solve the substance abuse issues in the community emerged as a key
The perception that the North Shore was immune to the serious problems associated with substance abuse was seen to be a critical factor in the early development of the SATF. It was almost as if the Vancouver experience, which at this time in the late 1990's was highly charged and very political with many drug overdose deaths and increasing Hepatitis C / HIV deaths resulting from intravenous drug use, seemed to ebb over onto the North Shore and motivate that community to take a preventative approach through the development of its own substance abuse policy. Part of the challenge was to ensure that the community understood the scope of the problem and was supportive of the efforts to address the problems, which were often controversial. Most activities under the harm reduction pillar (needle exchanges, crack kits) were difficult for communities to support when drug use was obvious and out in the open let alone if drug use was more discrete like it was on the North Shore. Presenting at a City of North Vancouver Council meeting in August 1998, a representative from the RCMP was responding to questions by Council on the severity of the problem on the North Shore. The response was that there were a limited number of IV drug users on the North Shore and that the problem is more discrete, involving a higher functioning group of people. At the same meeting, Alan Podsadowski, Executive Director of West Coast Alternatives Society, concurred by stating that
there isn’t an obvious problem on the North Shore but it is nonetheless a serious problem and widespread (CNV Council Report September 2, 1998). On the North Shore, the need to do a thorough and deliberate community consultation process to educate and garner support for the tools needed to address substance abuse would be critical.

Role of the First Nations

Part of what makes the North Shore unique is the existence of two First Nations as part of the political, cultural and social geography of the region. The Squamish First Nation and the Tsleil Waututh First Nation were active members of the North Shore’s Substance Abuse Task Force. Their participation on the SATF was preceded by their participation on the North Shore Congress, a political committee that worked on specific issues collaboratively on the North Shore and which was the organizing impetus for the SATF. Though the Tsleil Waututh First Nation elected to send a senior staff person to attend the SATF meetings, the Squamish First Nation regularly sent an Elder, which was considered to be unusual and which meant that the Squamish Nation felt that the SATF was doing important work. Both First Nations representatives regularly attended meetings of the SATF and participated fully in the development of the substance abuse policy.
Case Study: The Emergence of the Task Force

This case study provides a detailed overview of how the North Shore went about creating a Substance Abuse Strategy. There are three distinct parts of the process, which will be discussed in turn:

1. participation in efforts by the LMMA to create a Regional Substance Abuse Strategy (1997-2001) which was prior to the formal creation of the SATF but an important part of the process that led to its creation
2. the development of a governance structure and public process to create a North Shore Substance Abuse Strategy (1998-2001 note overlap with previous phase)
3. the endorsement of the Substance Abuse Strategy and the development of priorities and an implementation plan for the strategy (2001-present)

Part I – LMMA

The Lower Mainland Municipal Association (LMMA), now called the Lower Mainland Local Government Association, is a non profit organization that represents 33 Municipalities, 3 Regional Districts and has as its mandate to improve and refine the level and quality of services by Local Government to their citizens. In 1997 the LMMA, under the leadership of the City of New Westminster, was leading a regional initiative to develop a substance abuse policy for the Lower Mainland. The LMMA formally requested that the District of North Vancouver, the City of North Vancouver and the District of West Vancouver, Bowen Island and Lions Bay endorse its application to the National Crime Prevention program for funding to develop a Regional Drug Strategy. All North Shore Municipal Councils endorsed the request for support and in addition, other partners such as the RCMP, the North Shore Medical Health Officer and
various non profit organizations across the North Shore submitted letters of support for the LMMA initiative. However, each of the North Shore municipalities decided that the new subcommittee of the North Shore Congress, called the Substance Abuse Task Force, should be the organization that provides the leadership at the LMMA table for the regional drug strategy.

This example of an early political partnership between the five municipalities on the North Shore illustrates their commitment to dealing with substance abuse together and recognizing the importance of collaboration and coordination in addressing the issues surrounding substance abuse. Though the LMMA was really only seeking municipal support (and eventually endorsement) of its regional drug strategy, the support of other partners of the SATF, such as the School Districts, enhanced the overall potential success of the LMMA's efforts.

Records from the City of North Vancouver indicate that the impetus for the LMMA's initiative came in part from the City of Vancouver "Coalition for Crime Prevention & Drug Treatment" International Symposium held in June 1998, in which many municipalities, including those on the North Shore, participated. The LMMA wanted to apply to the federal government for $1.4 million annually for 5 years to develop the strategy. The proposed LMMA drug strategy had four main objectives:

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2 See Part II for a detailed description of the North Shore Congress
1. to identify the service needs and deficiencies in the region
2. to develop a funding protocol with the provincial government and service providers over the location and provision of recovery services
3. to develop locational criteria for the decentralization of services
4. to allocate seed monies for priority services (Larry Orr, Social Planner, CNV Council Report September 2, 1998, page 2)

The rationale for supporting the development of a regional Substance Abuse Strategy provided by Social Planning staff to municipal Councils on the North Shore listed previous reports on the incidence of substance abuse among residents as well as an acknowledgement that, though the substance abuse issues were nowhere near the critical and devastating levels that they were in the Downtown Eastside, the goal was to avoid such a scenario from ever happening on the North Shore. Comments from Social Planning staff articulated how a "coordinated response (to drug use and its implications) will help the Lower Mainland to deal with the problems that are unique to this area and that are common throughout the province" (Larry Orr, Social Planner, CNV Council Report September 2, 1998, page 4). However, a report by Mayor Don Bell, District of North Vancouver, indicates an important caveat related to municipal support for the LMMA's initiative. The report states that:

The District should ensure through our participation and support for this initiative that local concerns and achievements are incorporated into any regional strategy. .... District support for a Regional Drug Strategy should carry with it assurance that we will participate in developing the basic elements of the strategy through the LMMA (Mayor Don Bell, DNV Council Report September 3, 1998).
The LMMA was successful in its grant application to the National Crime Prevention Centre and the next step was to develop the strategy. At this early stage, the newly formed SATF felt that the LMMA could coordinate the overall strategy region wide and that the work to develop a separate North Shore strategy would not be necessary. Records also indicate that the Province established a Provincial Addictions Task Force at this time as well and the possibility of new or enhanced funding most certainly factored into decisions taken across the region about whether or not to participate in the regional drug strategy. The regional scope of the LMMA would make it a likely go to organization for the Province if the funding were to be formalized and distributed.

In the proceeding two years the LMMA went about the work involved in drafting the strategy. The SATF continued to be the main contact on the North Shore for the LMMA during this time and the work of the SATF appeared to be solely to act as the liaison to the activities occurring at the regional level.

In April of 2001 the LMMA circulated its draft 'Regional Action Plan to Reduce the Harmful Effects of Alcohol and Drug Misuse' to the North Shore Municipalities who in turn referred it to the SATF. The introductory statement of the LMMA's draft plan was;

The purpose of the action plan is to offer a framework for action for municipalities of the region that are prepared to exercise a leadership and facilitative role to reduce the preventable harm resulting from alcohol and

A report prepared by Social Planning staff from the City of North Vancouver and the District of North Vancouver provided some perspective for the five North Shore municipal Councils on whether or not to support and endorse the LMMA’s plan. The report applauds the LMMA for several strengths in the plan including adopting a ‘four pillar’ approach and a recognition that municipalities must be active partners in any comprehensive action plan around this issue. However, the report also notes that the efforts of the LMMA to create a region wide substance abuse strategy were flawed. A list of weaknesses was provided in the report, the most important of which was a criticism of LMMA’s ‘mandate drift’ from developing a strategy to proposing to become the municipalities’ agency to implement that strategy. To quote the report:

The Plan document does not provide a convincing argument why the LMMA should take on the quasi-governmental role of coordinating and directing substance abuse activities among member municipalities. Since the process did not include a clear-cut buy in form member municipalities, implementation on a regional basis is questionable. .... The precise roles of the municipalities, GVRD\(^3\), Health Regions, provincial ministries and First Nations, need to be clarified before the LMMA is given such a large responsibility. (Social Planning Reports, City and District of North Vancouver Councils, May 25, 2001)

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\(^3\) The Greater Vancouver Regional District (GVRD) is responsible for specific areas of regional governance such as regional planning and water/waste. The GVRD changed its name to Metro Vancouver in 2007.
It appeared that the LMMA embarked on a flawed process to get municipal support from the North Shore (and possibly other municipalities) for the approach it planned to take with regards to the regional implementation of the plan. All five North Shore municipalities passed motions that generally supported the plan but stated that more work needed to be done to clarify roles and develop criteria about how funding would be shared across the region. Therefore an outright endorsement of the LMMA's plan was not forthcoming. The North Shore instead turned its attention to developing its own Substance Abuse Strategy, regardless of whether or not the LMMA followed their recommendations.

**Part II – Development of the Strategy**

In 1998, the North Shore Congress, a political committee whose mandate was to work collaboratively to tackle issues that were of concern across the North Shore, identified substance abuse as a key area of priority that needed to be addressed. Membership on the North Shore Congress included elected officials from the District of North Vancouver, the City of North Vancouver, the District of West Vancouver, Bowen Island and Lions Bay as well as senior staff from Vancouver Coastal Health (which in 1998 was still the North Shore Health Region and had not yet been amalgamated into the larger health region Vancouver Coastal Health, as it is known today)\(^4\) and the two North Shore First Nations, Squamish and Tsleil Waututh. It was during this time that the LMMA

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\(^4\) Vancouver Port Corporation was listed in documents dated March 2002 as a partner in the SATF but was otherwise not identified in any other documents or the terms of reference of the
The North Shore Substance Abuse Task Force embarked on a plan to develop a regional drug strategy. The SATF became the lead group tasked with working with the LMMA in the development of that strategy, and as is described above, ultimately decided that a local Substance Abuse Strategy was required and preferred.

The North Shore withdrew, in part, because the process by which the LMMA had consulted with the North Shore was inadequate. There was only one public meeting planned for the whole North Shore in the process outlined by the LMMA for its draft strategy. This was considered to be inadequate. When the SATF was first ready to embark on a public consultation process with its draft Substance Abuse Strategy, it went to each of the five participating municipalities individually. So, buy in from all the communities that made up the North Shore was particularly important in the early development of the task force. By 2000 the SATF had developed its Terms of Reference and had formalized as a group.

The Terms of Reference included five key objectives for the task force:

1. survey and review substance abuse services on the North Shore
2. identify gaps in and issues with these services and recommend additional and/or changes to services (including but not limited to issues such as coordination of services, effectiveness of services etc.)
3. discuss other strategies and opportunities, such as policy, as they apply to substance abuse
4. consult with the community and service providers
5. develop an outcome-orientated strategy to address the issues identified that focus on the four pillars of community response to alcohol and drug abuse

SATF as a voting member and is therefore not listed as a true partner in the SATF for this research project.
misuse: prevention, early intervention and treatment, harm reduction and enforcement.

A key priority continued to be the partnership with the LMMA on the regional drug strategy; however, by 2000 the SATF had made the decision to focus their work on the development of a *local* plan that addressed *local* problems of substance abuse. Leadership during these early stages of the SATF was provided by Councillor Craig Keating and Councillor Bob Fernley of the City of North Vancouver. The process followed by the SATF was to take components of the various models available such as the one drafted by the LMMA as well as Vancouver’s *A Framework for Action: A four pillar approach to drug problems in Vancouver*, with a focus on the four pillar model and create a North Shore specific strategy that met the unique needs of the North Shore community.

The “task force initiated the strategy development with an information phase that included assembling current information and existing strategies and organizing presentations from service providers and other professionals in the field of substance abuse” (Larry Orr, Social Planner, CNV Council Report May 23, 2001, *page 2*). The SATF then decided that a ‘discussion paper’ should be developed based on the information collected and that it could be used as the basis for consultations with service providers and the community to get feedback. There appeared to be careful consideration given to the need for the community consultation process to be done comprehensively and with thought given to the
unique circumstances related to the reality of substance abuse on the North Shore. A City of North Vancouver staff report notes that "issues of substance abuse are complex, with strong and often differing views held by people. Gaining consensus among the stakeholders and the public on a North Shore Strategy will be a challenge" (Larry Orr, Social Planner, CNV Council Report May 23, 2001, page 3). There were five municipalities, two School Districts, two police forces and two First Nations that needed to be included in the consultation process, which was obviously a difficult task.

An action plan for this part of the work of the SATF was drafted for Council's consideration. It included dates between March/June 2001 for presentations from service providers to the SATF. In a memo to the SATF from a consultant in June 2001, two key questions are outlined for consideration and feedback from key stakeholders and services providers on the North Shore:

1. what needs to be done in the North Shore under each pillar? Prevention, treatment, harm reduction actions that are outcome based? What are the opportunities and what are the constraints?
2. who should fund and implement the priority North Shore actions under each pillar? Roles, responsibilities, jurisdiction, coordination, implementation, monitoring, evaluation, corrective measures/change, resource sharing (Judy Kirk and Company Consulting, Memo to SATF, June 13, 2001).

The feedback was to be provided through two workshops with service providers and the SATF. The results of this input were incorporated into the draft strategy and from July/September 2001, the draft plan was finalized. By October, it was
referred to the North Shore Congress and North Shore Councils and School Boards for endorsement and direction to complete the community consultation process. The timeline noted that community feedback, input and community forums on this draft strategy were planned for 2001/2002. The SATF planned on finalizing the Substance Abuse Strategy based on this community feedback in 2002 and then proceeding to final adoption by all organizations represented by the voting members of the task force.

Administrative support for the SATF was coordinated by the City of North Vancouver and paid for by all members of the task force which by 2001 was formally funded by the District of North Vancouver, the District of West Vancouver, Bowen Island and the City of North Vancouver as well as Vancouver Coastal Health. A report by City of North Vancouver Social Planning staff on May 23, 2001 makes the formal request for funding to support the SATF with $5000 to be contributed to the shared account for the purposes of hiring a consultant to support the task force. The total budget request made by the task force as a group to their respective Councils was not to exceed $20,000. The funding requests made by the member municipalities (excluding Lions Bay) were for the costs associated with hiring a consultant to facilitate workshops to get the important community feedback on the draft strategy noted above. These original funding requests eventually became budget line items for the City of North Vancouver.

\[5\text{ Lions Bay did not directly fund the SATF.}\]
Vancouver, the District of North Vancouver and the District of West Vancouver, with Vancouver Coastal Health also contributing significantly. It appears that Bowen Island and Lions Bay were only expected to contribute as was possible given their small size and limited capacity. This community engagement process and the development of the implementation plan for the strategy is the final phase of the case study on the emergence of the Substance Abuse Task Force which follows below.

Part III – Priority Setting and Implementation

By the middle of 2001, the Substance Abuse Strategy was drafted by staff with the assistance of consultants. Input was provided directly to the SATF from services providers and experts in the field of drug policy at the regular meetings of the task force throughout 2001.

Plans were then put into place to take the draft policy out to the community for feedback. One of the original criticisms by the North Shore of the LMMA’s attempt to draft a drug policy on behalf of the region centered on the public consultation process. The LMMA proposed only one public meeting on the North Shore, however it never actually occurred. The Executive from the LMMA, which included Councillor Fearnley from the City of North Vancouver, did present their plan to the North Shore Congress, but no further consultation with the public occurred because the LMMA was becoming less interested in pursuing it. Even though the North Shore demonstrated a partnership approach in addressing
substance abuse in the community through collaborative planning processes such as the North Shore Congress and the SATF, there was still a strong consensus amongst staff and elected officials that each of the five municipalities should be consulted individually as part of a comprehensive public engagement process.

In October and November 2001 five public meetings were held across the North Shore to solicit the public’s views and suggestions on the draft Substance Abuse Strategy put forward by the SATF. The input was used to revise and finalize the strategy before going to the North Shore Congress for approval in early 2002. There was a concerted effort by the task force to widely publicize these meetings to encourage people to attend and provide input. The meetings were publicized with articles in community newspapers, direct mail to individual households, through community connections such as the Parent Advisory Boards etc.

Though not stated overtly in the documents related to this part of the process, the SATF was likely worried that the harm reduction pillar of the draft strategy in particular may not be palatable for some community members. However, all indications point to a modest level of participation (110 people attended in total across the five municipalities) with a variety of generally supportive comments and feedback.
The following provides a summary of public input received as part of this consultation process as described in a report by Donald Golob Consulting in November 28, 2001:

1. overall support – public liked the multi-jurisdictional approach and a move away from shaming and blaming
2. support for politicians putting this so prominently on the political agenda – wanted a long term commitment
3. wanted the context of substance abuse set more clearly – i.e. what drugs are we talking about? Not just a focus on youth – should be for all age groups
4. overall support for the philosophy and approach of the strategy – time to approach substance abuse from a non-judgmental, comprehensive, multi-jurisdictional perspective that moves away from shame and blame
5. broaden the approach from a medical one to a health issue
6. agreement on the four pillar approach – agreement that the success of the strategy would depend on addressing all four pillars together
7. concern (but hope) that the philosophical differences between agencies would be difficult to address. Hope was expressed that all the groups represented on the task force will be able to continue with this level of resolve to work together to adopt a North Shore policy
8. weakness of the prevention pillar – not as much information provided – need to focus on that if ‘prevention is better than a cure’

The following represent some possible actions the SATF was asked to consider as part of the public engagement process:

Prevention:
1. education on illicit drugs, their use and the consequences
2. education on how to recognize the characteristics and behaviours associated with substance abuse
3. forums for teens and young adults on substance abuse
4. broaden and enhance programs and services available in schools – also a need to broaden the abstinence perspective such as the Drug Abuse Resistance Education (DARE) program
5. peer to peer education
Treatment:
6. need for integrated treatment facilities
7. innovative ways to provide treatment facilities via municipal by laws, municipalities to give land, public private not for profit partnerships. Capital funds an issue
8. role for NS Health to provide follow up care to those coming out of treatment
9. crisis line
10. better communication of existing services – especially in schools
11. better publicity of existing services

Enforcement:
12. ongoing training for police on substance abuse
13. alternatives to incarceration, for example drug treatment courts

Harm Reduction:
14. better communication and education about the purpose and benefits of methadone treatment

The next steps for the SATF were to provide clarity on the priorities of the Substance Abuse Strategy, and also to provide some clarity on how it was going to be implemented. There were also some concerns raised that it was necessary to coordinate existing services and that the SATF may need to hire a coordinator to do that. There was also a need to investigate and monitor the use and success of the four pillar approach in other jurisdictions – for example Vancouver and Zurich, Switzerland and to query whether or not the four pillars were being implemented in a linked and coordinated manner. Lastly, the public wanted the SATF to ensure that the implementation phase was explicit about what individuals and communities could do to address the problem of substance
The North Shore Substance Abuse Task Force

abuse. Community capacity building appeared early on in the public process as an important tool to consider when implementing the strategy.

The feedback from this phase of the process was incorporated into the strategy, and in 2002, the North Shore Substance Abuse Policy was adopted by each of the North Shore Municipal Councils and referred to other partner agencies and organizations on the SATF for endorsement/approval.

The following provides an overview of the mechanisms put in place early on by the SATF that speak to implementation of the policy and illustrate the task force’s continual commitment to working together and the importance of partnerships.

By 2002, the strategy was endorsed by all the voting members of the SATF. The next phase of the process was how to implement the strategy. The approach taken by the SATF was to hire a consultant, Abrahamson and Associates, to meet with stakeholders to develop priorities for each of the four pillars of the strategy. This was done with two groups. The first was the Professional Advisory committee which was made up of service providers across the four pillar delivery model on the North Shore including law enforcement. Their task was to review the strategy actions, examine the service system, gaps in services and potential service demand on the North Shore and provide advice to the task force on which areas should be considered priorities for implementation. This resulted
The North Shore Substance Abuse Task Force

in a short list of sixteen priority actions for consideration by the SATF. The second group was a Citizens Advisory group that met to provide insight and comments on the sixteen priorities developed by the Professional Advisory group. By way of summary, the Professional Advisory group’s priority actions considered four theme areas. These are:

1. implement a communications and education strategy for the North Shore
2. enhance school based prevention activities
3. increase access to adult and youth treatment counselors on the North Shore
4. develop a spectrum of facility opportunities including detox services, support recovery beds and treatment services (Abrahamson and Associates, Report to the SATF, November 14, 2002)

It is interesting to note that the Citizens Advisory group agreed with all of the recommendations put forth by the Professional Advisory but that they voiced concerns about the decision to ‘develop a spectrum of facility opportunities’ because of the concerns related to a community backlash and a ‘not in my backyard’ or NIMBY attitude. In addition, staff notes attached to the report prepared by the consultants state that more details were needed with regards to the specific actions to be taken, who will do what, costs and identification of funding sources – all excellent questions when considering how move from policy creation to implementation. Nonetheless, all four were presented and endorsed by the SATF without further clarification or discussion as far as could be found in the file/minutes.
In 2003, the task force focused on developing a communications plan as the first step of the implementation plan noted above. The SATF was particularly interested in the prevention pillar and felt that a communications strategy was a good place to start the implementation of the SAS. Actions included community forums, written material such as brochures and a speaker’s bureau to discuss issues/needs (Author unknown, Report to the SATF, November, 2003).

By 2004, the scope of the work related to implementation became a concern and social planning staff were asked to write reports to their respective Councils regarding funding requests to hire a coordinator for the SATF. These efforts were ultimately successful and resulted in budget line items for the City of North Vancouver, the District of North Vancouver and the District of West Vancouver. A coordinator was hired in 2004 to implement the four priorities noted above.

Between 2004 and 2006, the SATF worked toward furthering the implementation of the SAS. Much of the interest and focus during the development of the strategy was on the prevention pillar of the Four Pillar approach used by the SATF. As such, a sub-committee was struck with a mandate to educate the broader community on the issues surrounding substance abuse. Facilitated by the SATF Coordinator, the sub-committee consisted of junior planning staff from the City of North Vancouver and the District of North Vancouver whose focus was working with youth. The goal the sub committee worked toward was to educate
young people (and their parents) about the tenets of prevention, which would become the main thrust of the SATF’s implementation strategy. However, the information on the work activities of the Coordinator regarding this part of the implementation of the SAS is limited. There was one town hall style meeting for parents and their teens to educate and spark dialogue about substance abuse which was held at a local secondary school and was well attended. However, there is very little information available about what else the SATF planned to do with this part of the implementation of the SAS.

During this time, VCH went through a reorganization process and proceeded to redirect adult substance abuse counseling dollars towards youth prevention focused activities as a result of prevention being a key focus for the SATF. Four ‘Concurrent Prevention Workers’ were hired by Vancouver Coastal Health and deployed across the North Shore to work in an outreach capacity with young people who had both mental health and addictions problems. While the hiring of new youth outreach staff by Vancouver Coastal Health seemed like a very positive step forward and a success with regards to implementation for the SATF, it appeared not to be so. The introduction of these outreach workers caused friction with the existing youth outreach workers in the community, many of which were doing almost the same work with young people that the concurrent disorder workers were asked to do. In addition, the existing staff were being displaced by these new VCH staff in schools across the North Shore. Junior planning staff
from three municipalities as well as local non profits working with young people would have made these facts clear to the SATF but they were not part of the SATF and never given the opportunity to provide feedback on the possible duplication of service and the impact it may have on the North Shore. The end result was that the existing youth outreach staff as well as the local non profit alcohol and drug service providers, who employed a youth drug and alcohol counselor, began losing referrals and became increasingly concerned about the ability to serve youth in a coordinated way on the North Shore (Vancouver Coastal Health Youth Services Review, 2007). The Concurrent Disorder Workers remained employed by VCH until 2009, when a new Director for Mental Health and Addictions finally reorganized the VCH youth staff and redirected their work into the elementary schools and toward clinical counseling, which was a recognized gap in the youth services continuum for years. This reorganization was not initiated by the SATF and did not involve the membership of the SATF but rather consultation with front line service providers working with youth across the North Shore.

By 2006, the SATF had lost the participation of the Medical Health Officer, who was replaced by senior addictions staff from VCH, as well as all three social planning staff representatives who had either retired or taken on new positions. A review of the previous three years of implementation by new Social Planning staff revealed that very few tangible results were achieved and raised questions
about whether the strategy was working and achieving its goals (in effect, was it actually being implemented)? The coordinator hired in 2004 was let go and there was a request by staff that a facilitated session with SATF members be held to discuss whether or not the committee wanted to continue to exist.

The consensus of that facilitated session was that the group should continue but that the Terms of Reference should be updated to indicate the new mandate of the group which was agreed upon to be advocacy, leadership and collaboration. The group also changed its name from a task force to a working group. The membership felt that the name task force implied that a task needed to be completed (in this case the creation of a substance abuse policy) and that, once completed, the task forces’ work was finished. The membership felt that, in order to better reflect the on-going work related to the implementation of the substance abuse policy, a name change to a working group was necessary.

As a result of the facilitated session, a two year work plan was created for the newly named Substance Abuse Working Group (SAWG) and sub committees were struck to begin work on each of the work plan items (there were six in all). Over the next two years the SAWG met quarterly to implement the work plan. Staff continued to support the group and in effect, did the work of implementation in partnership with other committees on the North Shore that had front line staff with a better understanding and ability to get the work done on the ground. This included the Action on Prevention Task Force which drew from all the
organizations represented by the SAWG, but from their front line staff and managers rather than their political representatives. Though the Action on Prevention group was effectively implementing the prevention components of the SAS (which were a priority for the SAWG), they did so without any realization of implementing the actual SAS itself.

In 2008, a review of the completed two year work plan was done and a discussion of next steps was facilitated with the group. At this time, the West Vancouver Mayor stepped down as Chair and left the working group. Her leadership was significant and her departure had a big impact on the SAWG. It was clear that again, the working group struggled to do the work necessary to implement the work plan and without the leadership provided by the Mayor, there was a concern that the group would fold. It was also becoming increasingly clear that as elected officials, the members didn’t have the personal capacity nor the mandate to implement the SAS and that this task should in fact be delegated to the appropriate staff at each member’s organizations. However, at the facilitated session in 2008, the SAWG insisted that the working group was important (and as a political group it was), and felt that a new work plan with refreshed terms of reference should be completed and that the working group should continue to exist.
In 2008, Councillor MacKay Dunn from the District of North Vancouver became the new Chair. A new work plan was developed but during its implementation into 2010 very little has been accomplished. The SAWG appears to spend much of its time revising (but not adopting) the work plan and terms of reference with little or not time spent on doing the work contained in the work plan.

The SAWG continued to meet quarterly, has the same organizational representation as when it was first created, but there are several new members (who were only recently elected/appointed) so work related to the SAWG is more about education and clarification of roles and responsibilities than any fulsome discussion of how to implement the four pillar strategy that was the basis of the original SATF. It remains to be seen if the SAWG can move again towards implementation or if the group will fold, assuming that the work to create the strategy was all that was required of them.

Analysis

Introduction:
The literature on drug policy making examined in this research paper explores the link between the need of some cities to create drug policies and the efforts by those cities to look to other cities to see how drug policy making is done elsewhere. Much has been written about both the 'Vancouver Model' and the many European cities, particularly in Switzerland and Germany, that have used a
collaborative planning approach and have shared policy with their peers. The consensus by many researchers is that this approach has been entirely successful (see Kübler and Wälti, 2003, McCann, 2008 et al) in addressing the diverse policy and implementation needs associated with the complex problem that is substance abuse. In this case, success includes a diverse group of representatives coming together to focus on a specific problem, it includes a variety of partners that are all working toward the same goal and have something specific to contribute with regards to implementation (usually organized around the four pillar model) and finally, includes a way to address and deal with change over time as personnel come and go, specific issues come up, are addressed and then replaced with new challenges etc. The collaborative planning approach appears to provide the flexibility needed to create success over time. However, the experience on the North Shore appears to be less than perfect. That is to say that, though the SATF was created in a collaborative spirit to be (and still is) a powerful group of the North Shore's most influential policy makers, their ability to do more than just create the policy has been limited.

Reasons for this are numerous, including questions of jurisdiction, budgets and capacity. There is no regional benchmark to measure the SATF against (i.e. there is no regional substance abuse policy or regional substance abuse task force, early efforts to create a regional drug policy by the LMMA described in this research project ultimately failed), and a direct comparison to Vancouver or even
an outlying municipality such as Surrey is difficult because of the significant
differences in demographic make up, financial contributions to provide both
administrative support and implementation as well as the variety of potential
partners in the collaborative process (i.e. municipal police forces vs. RCMP, other
health authorities and school districts and few communities with any real
involvement of the First Nations). Given these challenges, it is difficult to
determine whether or not the North Shore’s SATF really has achieved something.
Though the task force has been very successful in bringing all the political
leaders to the table to address issues related to drug abuse in their community,
the ability for the group to implement their four pillar model has been limited. The
following section of this research project provides an analysis of the SATF
partnership itself, which speaks to its collaborative approach to drug policy
making outlined in the literature review. Also included are some thoughts on the
challenges the SATF came up against with regards to implementation. The
SATF did work collaboratively and did look to other municipalities, especially
Vancouver, to understand the complexities of developing drug policy, however,
the successful implementation of the drug policy was particularly challenging.
Those interviewed for this research project will speak about why this might be
and will provide some insight into how the task force might deal with its
implementation challenges.
**Partnership Framework:**

The analysis section of this research project provides an in depth look at the characteristics of the North Shore SATF as a way to understand whether or not the way the partnership was formed, the members that signed up, and the supports put in place, had an impact on the relative success of the task force. Information is revealed by way of six interviews with key members of the SATF, some of whom are still members of the Task Force today. These include municipal planners, staff from Vancouver Coastal Health as well as several municipal politicians who were active in the early days of the SATF partnership.

The analysis of their input is facilitated by Asthana, Richardson and Halliday (2002) who propose a simple framework with which to evaluate the partnership approach. Asthana et al. argue that the value in their approach lies in the ability for groups to use their framework tool to evaluate whether or not their partnerships are working effectively so that they can move from the “rhetoric of partnership working into practical reality” (Asthana et al, p.781, 2002). They placed emphasis on creating a framework that “was sufficiently comprehensive to accommodate the complexity of issues that arise in the building of partnerships and was intelligible to all stakeholders (i.e. that had a practical rather than a theoretical basis” (Asthana et al, p.782, 2002). As has been discussed previously, inputs for the framework include things such as questions about funding for the administration of the partnership, the needs of the partnership,
leadership and accountability among others (please see page 17 for the full list of inputs).

The following provides an analysis of the SATF based on the framework developed by Asthana et al. All eight components of their framework are explored based on the responses gathered during the interview phase of this research project. And, as noted in the literature review, the research revealed two additional elements which are also important, which are representativeness of the partnership and the impact policy transfer may have on the partnership.

**Funding for the administration of the partnership**

The ability of an organization or a group of organizations to achieve success in policy making is often directly linked to the amount of funding and/or dedicated staff time (considered as funding in kind) allocated. In the case of creating drug policy, there is a wide range of possible partners, possible approaches and possible outcomes that together create a complex process that ultimately requires funding. These include health officials, police (in the case of the North Shore there is both a municipal police service in West Vancouver and the RCMP that serves North Vancouver City and District together), service providers (both non profit, and private) and municipal, provincial and federal government staff are the obvious ones but there are likely others as well.
So, the ability for a group to find funding for the administration of the partnership is a critical component of its success. Setting up meetings, creating minutes and other important documents necessary for the task force’s ongoing work, as well as catering and public consultation must all be resourced. And while this kind of administrative work is important, the staff time from member organizations to lead the process is critical in moving the group forward and must also be resourced. There is a lot of work that needs to be done and the question that always comes up is: who is going to do that work?

**Larry Orr, Community Planner, City of North Vancouver:**
We had to go to the municipal Councils to get approval for staff time. The challenge was that it was a lot of work to do off the side of our desks. Not being able to dedicate one person to do all the work was difficult. We needed resources to implement the work plan.

The scope of the work required was considerable given the complex nature of the task force. See Table 2 below for a summary timeline and work plan for the SATF. Planning staff realized early on that the magnitude of the task of developing a substance abuse policy for the North Shore required additional support than what they alone were able to provide. The traditional approaches of having municipal planning staff simply attend meetings (with their attendance being the main contribution) was not enough. More active participation was required. The way in which this is traditionally done in municipalities is by hiring either a coordinator or a consultant (short term). The North Shore SATF decided
on the latter and ultimately hired three different consultants to carry out the various work plan items of the task force.

Table 2. Summary timeline and work plan for the SATF

<table>
<thead>
<tr>
<th>Work plan Item</th>
<th>Date</th>
<th>Task</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with LMMA / Creation of the SATF</td>
<td>1998-2000</td>
<td>• act as the North Shore liaison group for the LMMA&lt;br&gt;• begin to develop the partnership framework to create a North Shore strategy</td>
<td>• Municipal staff support to the SATF&lt;br&gt;• Karen Abrahamson Consulting</td>
</tr>
<tr>
<td>Development of the Strategy</td>
<td>1998-2001</td>
<td>• do a needs assessment / gap analysis&lt;br&gt;• consultation with the public&lt;br&gt;• develop an outcome orientated strategy</td>
<td>• Municipal staff&lt;br&gt;• Judy Kirk Consulting</td>
</tr>
<tr>
<td>Priority Setting</td>
<td>2001-2002</td>
<td>• Public meetings on draft strategy</td>
<td>• Municipal staff&lt;br&gt;• Donald Golob Consulting</td>
</tr>
<tr>
<td>Implementation</td>
<td>2002 onwards</td>
<td>• Priority setting&lt;br&gt;• Consultation with a professional advisory group&lt;br&gt;• Consultation with a citizens advisory group</td>
<td>• Municipal staff&lt;br&gt;• Karen Abrahamson Consulting&lt;br&gt;• Coordinator</td>
</tr>
</tbody>
</table>

Larry Orr, Community Planner, City of North Vancouver: Karen Abrahamson was hired to do a lot of this in the early years – she did the documentation for the task force as well as agendas, reviewed meeting notes, pulled together information etc. This worked well.

Dr. Brian O'Connor, Medical Health Officer, Vancouver Coastal Health: Consultants were also hired at various points – Karen Abrahamson is an example, she did good work for the committee. All decisions though were ratified by the SATF. The funding was meant to support the task force.
However, the ability for each of the participating partners of the SATF to secure funds for the task force was not uniform. This was a complicating factor for the North Shore with so many different members and ultimately different decision makers all needing to agree to support the work of the task force.

Mark Bostwick, Social Planner, District of North Vancouver:
DNV (District of North Vancouver) funding was tricky. At first, I think we were able to draw from some un-used money in Planning. Then a one-time amount of money in the annual municipal budget. Then money for SATF work which was carried over from a previous year. Eventually, a line item in the municipal budget. District support came in part because both the City and West Vancouver were on board and (Brian) O’Connor’s credibility was high.

Part of the challenge in establishing a municipal budget line item for substance abuse was the question of whether or not the municipalities even had a legitimate role to play in this issue. Services and supports to address issues related to substance abuse have traditionally been a provincial government responsibility. Even though there was support for the concept of harm reduction and this was listed as a priority in the early consultation work done by the SATF, the question of who would fund these components of the strategy was less clear. The municipalities did not (and likely would not) fund detox services, addiction counseling services, rehabilitation etc. because it wasn’t their jurisdiction but the jurisdiction of the provincial government. However, providing funding to support a coordinated community response to substance abuse was seen to fit with the
mandate of municipal responsibility, as was developing a policy response to the
issue at the local (i.e. municipal) level.

Mark Bostwick, Social Planner, District of North Vancouver:
The North Shore municipalities, and especially DNV, had a long historical
relationship with Lions Gate Hospital and North Shore health services. Before re­
organization of health services into VCH the municipalities were direct funders.
Generally Lions Gate has been seen as “our” hospital, not just a cog in a larger
health provider system. Similarly North Shore municipalities began to see
themselves as part of a larger health fabric, e.g. striving for “healthy
communities.” This was reciprocated by health authorities working from a
“population health” perspective, i.e. community health, not just sick patients.
Even the (North Vancouver) Recreation Commission began to view itself as a
health facilitator. In this context issues addressed by the municipalities
overlapped with the issues of substance abuse: substance abuse and seniors’
isolation; substance abuse and homelessness; substance abuse and youth
alienation; substance abuse and mental health/dual diagnosis; substance abuse
and crime. Thus the municipalities had every reason to be full partners in any
substance abuse strategy and implementation.

Once the membership of the SATF concluded that there was in fact a role for
each of them to play in developing a substance abuse policy for the North Shore,
the next question was how the resourcing of the work required would be
organized. The task force decided that the best way to generate funds to support
the work was to establish a funding formula based on the population of the
municipalities. Those partners whose mandate included one, two or even all five
municipalities would pay accordingly (for example Vancouver Coastal Health’s
mandate was for the entire North Shore therefore it had to pay a portion for each
of the five).

Councillor Doug MacKay-Dunn, District of North Vancouver:
One of the first questions was how will we pay for all of this? There was political
traction for the issue so money did follow. Staff developed a funding formula to
make it work. Everyone wanted to be involved because of everything going on
over town in Vancouver. This issue became a ‘cause celebre’ for the North
Shore.

Councillor Alison Morse, Bowen Island Municipality:
Money came from the Health Board, the School Districts, and the municipalities.
Everyone kicked money in – everyone realized that we had a problem. We
needed to figure out what the gaps in service were. The funding contributed was
based on a head count and that seemed to work well.
It appeared that one of the initial successes of the SATF was the ability to get all partners to contribute some funding to begin the work ahead of them. The legitimacy brought by the Medical Health Officer that substance abuse was a health issue and a community issue proved to be important and legitimized the participation of the municipalities in developing a funding stream to create a substance abuse policy. Asthana et al. indicate that funding is a necessary input but go on to state that “the provision of financial resources is an insufficient condition for partnership working. A number of less tangible factors also act as key inputs to the process” (Asthana et al, p. 786, 2002). That is to say that all eight of the characteristics of partnerships must be present in some significant way in order to be successful. Though funding can often be the most difficult one to get, without the rest of the characteristics outlined by Asthana, the partnership would surely fail.

By 2008 when the SATF was struggling to find its role and discussed ways to implement their work plan, a financial update provided by staff revealed that they had close to $50,000 in their accounts. Regardless of their apparent wealth as a committee, there was little agreement on what to use the funds for and what parts of the work plan could be finalized and approved by the committee with an implementation plan attached. A review of the expenditures of the committee reveals that in the last five years, the group has spent virtually none of its money,
other than to pay for a clerk to provide administrative support to the committee and for catering their quarterly meetings. As a result of this, the municipal budget lines described by the membership above were lost. It was difficult for staff to make a case for keeping a budget line in the municipal budget process for a committee that had $50,000 in its accounts and no plan on how to spend it.

**Based on need**

A second component of the framework established by Asthana et al for rationalizing whether or not a partnership was likely to be successful was whether or not it was based on need. That is to say: did the North Shore SATF come together because of a concern about the effects of substance abuse in the community and what the services for those involved were? Information provided by key informants in this research paper indicates that, though there was consensus that there was a need to address the issue of substance abuse on the North Shore, there were differences in emphasis of what to do about it. The North Shore had decided to model their strategy to that of the City of Vancouver’s – that is a ‘four pillar’ strategy that addressed prevention, treatment, enforcement and harm reduction. On the issue of need however, there seemed to be greater emphasis placed on the prevention pillar than the others which created some disagreement on what the high priority needs actually were. However, before examining this in more detail, the following provides an overview of how the SATF came to adopt a four pillar strategy and what individual members felt the strengths of the approach were.
Dr. Brian O'Connor, Medical Health Officer, Vancouver Coastal Health:
The work was born of an identified need to address substance abuse in the community. It ended up on the North Shore Congress agenda – which gave the issue legitimacy. Staff presented it as a four pillar method from the outset. Everyone understood that it needed to be that way. Not just about enforcement. Staff gave reasons for it. There were no nay sayers. Some of the key decisions that shaped the SATF and its strategy included:

- recognizing that a comprehensive strategy was required (this was impacted by the experience of Vancouver);
- recognizing that the North Shore, including the municipalities and First Nations should be treated together as a broad community;
- agreeing that a strategy should pinpoint and prioritize implementation measures;
- recognizing that political support, notably Council support, was vital (i.e. that the ball could not be carried by the Health Region alone);
- recognizing that funding would be required and;
- recognizing that the general public and specific interest groups must become more aware and more involved in solving problems.

There was no political opposition, there was agreement to move forward – then it happened.

It was clear that the SATF recognized early on that a comprehensive approach was necessary. The four pillar model was used with no objection from the group. Agreement on the model was important, but Asthana et al argue that what is more important is that the partnership comes together because of a real need to address an issue. In this case, there does appear to be some disagreement in the emphasis placed on some parts of the four pillar model, although ideally they would be weighted equally.

Councillor Alison Morse, Bowen Island Municipality:
We talked with all agencies during the first year to become educated. It was also a way to get everyone involved in a consistent way. We met with everyone – tried to quantify the problem which can be difficult because the stats are not always consistent. I thought it was important that we (i.e. Bowen Island) be part
of it and something that we should be involved in. First milestone was to quantify the problem. The second milestone was about how we deal with the problem. Issue was with prescription drugs and seniors – a big concern at the time - alcohol was an issue as well. We hired Karen [a consultant] to look at what was available for services for substance abuse – she created a report for us. We knew we needed treatment. Harm reduction was one of the things we recognized as important. There wasn't a lot of heated debate about this.

Councillor Doug MacKay-Dunn, District of North Vancouver:
HIV was a big issue. The needle exchange [in Vancouver] wasn't helping to save lives. I didn't agree with the City of Vancouver approach – there was too much harm reduction and not enough detox and rehab. Why? Because it's cheaper (short term). The money should go to prevention and detox and rehab. I was prepared to suggest that the money should come out of enforcement and go to rehab and detox. There is a huge cost of processing a drunk/addict – jail, hospital, involves police ambulance, fire emergency services and then others in the ER have to wait. There is a stress put on the medical staff because of this which isn't fair. There wasn't a lot of discussion about harm reduction other than setting up a needle exchange. There was a lot of process. Most North Shore folks are in denial – don't see evidence of drug use therefore presume it's not an issue. There was a lot of discussion about prevention. This was a good role for the School District – not just about street/prescription drugs but about alcohol too, especially among young people – a huge issue.

Mark Bostwick, Social Planner, District of North Vancouver:
In the wider community, including the media, substance abuse (and what to do about it) was a “hot button issue” that sometimes stimulated fierce rhetoric. It took courage for public officials, especially elected ones, to take stands on the four pillar approach.

As can be seen from the above comments from the SATF membership, though there was agreement that the strategy be based on need and that the approach should be a four pillar approach, there was some disagreement amongst the politicians and even the community about where the emphasis should be placed. As the substance abuse strategy evolved, it became clear that there should be a
focus placed on prevention. Though there appeared to be some disagreement with modeling the approach after the City of Vancouver four pillar strategy, with that city's emphasis being placed on harm reduction, generally speaking the membership of the SATF was in agreement that the approach should be comprehensive and include all four pillars.

However, one of the challenges the SATF had was to satisfy the rest of the respective Councils on the four pillar approach. Comments made in the media about a City of North Vancouver Council meeting in 2001 articulate the kinds of issues the politicians were grappling with:

While services are being co-ordinated, the task force should ensure services are not clustered in one geographical area, Councillor Bob Fearnley said. A neighbourhood can be negatively affected by clustering that can attract a significant number of substance abusers who may bring problems with them to the community, he added. "One concern I've heard from people I've spoken to is that many people with this health problem engage in criminal activity," said Councillor Barbara Perrault. She noted that substance abuse is now more commonly seen as a health issue. Substance abusers often commit crimes to support their addictions because to publicly seek help forces them to be stigmatized, Councillor Keating responded. "If my next door neighbour had cancer, I wouldn't expect them to not make it public or seek treatment. It's the reverse with drug use and that makes it unique amongst health issues," he said. Some people who support themselves through criminal activity exploit drug users, keep them away from health services and get them involved in crime, he added. (North Shore News, April 2001).

It took courage for the membership of the SATF to convince their respective colleagues that the approach (i.e. the four pillar approach, and one that included
harm reduction) was the not only the right thing to do, but was the best way to achieve success.

**Larry Orr, Community Planner, City of North Vancouver:**
*The work that I did was exploratory. For example I had to look into what the relevance was and how it impacted the municipality, the extent of the problem etc. There was interest in the impact substance abuse had on youth. The municipalities spent money on youth services so there was a real interest in this area. There was a real focus on prevention – publicity, education and prevention is the key.*

It is important to distinguish between the need to address the issue (in this case substance abuse) in the community and the need to do so as a partnership. Both are equally important. Asthana et al. place emphasis on the importance of motivation and its effects on ‘need’ in their partnership framework. They state that “motivation for collaboration takes many different forms and all may have a bearing on the subsequent strength and sustainability of partnerships. Sometimes agencies agree that there is a need to collaborate because there is a political imperative to do so … this can provide a catalyst for real commitment on the ground” (Asthana et al, p. 786/787, 2002). The SATF agreed early on that there was both a need to collaborate together and that there was a need to address substance abuse in their community. However, to date, the SATF has not been very successful in the implementation of the strategy and in fact did not translate the need to collaborate to develop a comprehensive plan into a successful way to tackle substance abuse on the North Shore on the ground.
Supports are in place via dedicated staff

Asthana et al. contend that one of the key characteristics of partnerships is the existence of dedicated staff to support the partnership. In the case of the North Shore’s SATF, the politicians that were the voting members of the task force brought with them dedicated staff whose purpose was to support the work of the task force. This work was supplemented by the hiring of consultants on an as needed basis (which in the early years of the task force was quite frequent, with upwards of $70,000 being spent on consultants in the first four years). So staff participated as a result of their political bosses being members of the task force. Several key staff members took on extra responsibilities, particularly the municipal social planning staff from the City of North Vancouver, the District of North Vancouver and the District of West Vancouver. However, “street level bureaucrats are notorious for being too busy coping with their day to day problems to recite to themselves the policies that they are supposed to apply” (Pressman & Wildavsky, p. 179, 1979). The municipal staff that took the lead also had full time jobs and other files to contend with and did not have the capacity to provide the support necessary for the committee. A dedicated position was required and over time, the SATF did hire a coordinator to provide that function to the group.

Mark Bostwick, Social Planner, District of North Vancouver:
At the beginning the primary stakeholders called together by the Public Health Officer included the three municipal Social Planners, Police and RCMP, West Vancouver School District, and several people associated with Vancouver
Coastal Health. As I recall some of the agencies that delivered alcohol and substance abuse services were not invited. I am not sure why this was so.

The Task Force depended heavily at the beginning on the three social planners and especially Brian O'Connor whose office provided meeting space, scheduling, etc. Secretarial help was provided by the City of North Vancouver (CNV) and later the CNV staff administered financial matters (i.e. billing the rest of the members). I presume this approach was selected because senior management considered us the appropriate staff. Eventually the SATF developed a more elaborate structure with a kind of "inner working group" (3 Social Planners, Brian O'Connor) who met between meetings of the SATF which was expanded to include a variety of agencies and organizations. My involvement really began in 1999 when, with departmental and Council approval, Social Planning held the "District of North Vancouver Substance Abuse Symposium". This was a day-long video taped educational session. Speakers included academics, reps from agencies, etc. The public was invited, but not a lot showed up. However, the symposium did illustrate the relatively complex issues involved, the need for multi-agency action, and that the issues had political interest (e.g. people like MacKay-Dunn). It also had the effect of making room for my continued involvement in this issue, including the SATF. The issue became part of my annual work plan.

As you can appreciate the role of a social planner in this kind of effort is relatively complex. As applied specifically to the SATF I acted as a "conduit" between SATF and DNV, between DNV and other municipalities, internally between staff at DNV, and between SATF and Council from time to time. In addition, of course, I went to many meetings (especially various VCH groups) as a DNV/SATF person (showing the flag, so to speak). Occasionally, I acted as an aide de camp for politicians (e.g. accompanying Cllr. Janice Harris to meetings with native groups).

It is also interesting to note that during the time that the LMMA was interested in developing a regional substance abuse policy, staff support was a key issue for them as well. The LMMA had several municipalities that spearheaded the initiative, which was very important since the LMMA didn't otherwise have any staff that they could use to do the work required (which was very similar to what Mark Bostwick describes above).
Councillor Bob Fearnley, City of North Vancouver

The City of New Westminster took the lead for the LMMA. They had a planner who was an up and coming Planner at that time that was the lead staff person for the initiative (for New Westminster but did a lot of work for the region). She is now the Director of Planning – this work was a great thing for your career! Having strong staff is key. A lot of wordsmithing was done on the regional strategy and many of the staff wanted to get on with it. Politicians and the police did most of the wordsmithing – you needed good staff to navigate through all of this, it was critical to have them in place.

The fact that the LMMA also struggled with staff capacity to carry out its work is relevant here in the frustration articulated by Councillor Fearnley. This was made available in part because the elected officials in New Westminster were particularly interested in the work the LMMA was doing and therefore designated a planner to provide this support. The LMMA relied on the staff from the City of New Westminster to provide the support required for that committees work on substance abuse policy. Councillor Fearnley gives insight into the important role played by staff in managing the wordsmithing done by the politicians around the table and the effort it took to move a group forward.

So the interest and support from staff was a key factor in the initial success of the SATF. However, the loss of the primary staff support representatives in 2005/2006 may have led to its inability to successfully implement the policy developed in the early days of the SATF. As described above, the key staff were the three Social Planners from the City of North Vancouver, the District of North
Vancouver and the District of West Vancouver, with leadership provided by the North Shore’s Medical Health Officer, Dr. Brian O’Connor.

In 2005, Larry Orr took a new position within the City of North Vancouver and left the task force. In that same year Mark Bostwick retired from the District of North Vancouver and Richard Wagner left his position in the District of West Vancouver due to health issues. In 2006, Brian O’Connor also left the committee. All four were replaced with new staff who knew very little about the history of the task force and the work done to date. VCH replaced Dr. O’Connor with a Director of Addictions position, which has since had a lot of turnover. So, the key supports provided by these staff all left within 15 months of each other, which effectively removed the support the SATF required.

Councillor Alison Morse, Bowen Island Municipality:
In 2006 there was a huge turnaround of people (staff and politicians). In 2006 there was a move to a co-chairs model (Cllr. Keating was our former Chair and was re-elected but didn’t come back to the committee). Cllr. Doug MacKay-Dunn and Mayor Pam Goldsmith Jones became Co-Chairs but I feel that the Co-Chair system doesn’t work. Many of those that left were key to understanding the four pillars and the spirit of the committee. We made the mistake of not reintroducing the four pillar strategy at the beginning of each year for the benefit of new members. The change over in people was not good. We went from having decision makers at the table to having junior staff (i.e. from the RCMP Superintendent to a Constable). And I think that the wrong VCH person is at the table currently – we need the Medical Director AND the Policy Director – even better the Medical Health Officer. Many of those that left were key to understanding the four pillars and the spirit of the committee.
The change over in staff support, in the Chair position, the move to regionalization of the health system and the loss of Brian O’Connor’s direct involvement as well as the junior staff from the police departments now taking the place of Chiefs of Police as voting members all appeared to dilute the task force and added to its difficulty in moving from developing and adopting a substance abuse policy to implementing it. This illustrates that even though staff supports were in place throughout, when the original staff left the committee, and when some of the original voting members left the committee, the ability of the partnership to function to its full potential was negatively affected. It may not be sufficient to say that having dedicated staff in place is enough. What is required is a clear work plan and set of expectations so that when staff change (because they always do) the direction of the partnership is clear and does not risk falling apart when new faces are charged with taking the lead.

That there is active leadership

It’s clear from the interviews that there was broad consensus that the task force was necessary, that it required the participation of both politicians and staff from the various North Shore municipalities, and other key organizations such as Vancouver Coastal Health and the two North Shore School Districts.

Councillor Doug MacKay-Dunn, District of North Vancouver: The three North Shore municipalities were the fuel that drove the car. Coordination and leadership was provided by Brian O’Connor. He had great credibility. He spoke of the issues well – he did the work well and eloquently. It wouldn’t have happened without him. He cut through the BS. He had a vision.
Everything was happening over town in Vancouver, it was the ‘it’ issue and the NS wanted to emulate it.

However, even though each of the five municipalities asked that one politician be assigned to the SATF, true leadership on the committee was perhaps fleeting.

Councillor Bob Fearnley, City of North Vancouver
This issue is vulnerable politically – being tough on crime is an easy sell and a good way to beef up budgets (i.e. police) and to get ‘new toys’ (equipment for police/forensics etc.). Politicians see drug strategies as a vulnerability. People just hammer you with these things, they can be very critical. If you support harm reduction you’re being soft on crime which is not popular amongst the voting public. Some politicians jumped on the band wagon but didn’t actually do anything. Even though I was the rep for the LMMA, the SATF was seen as prestigious and another politician got the job from the City of North Vancouver. If you were career minded at all it was just the committee to be on – for the first several years anyway. In the last four years not so much.

In the case of the SATF, it would be more useful to divide Asthana et al’s partnership framework category of ‘active leadership’ in two parts. The first would be the voting membership (that is the political leadership), with the second being staff leadership. It appears that during the first several years of the SATF, when the group was developing the substance abuse policy, there was active leadership by both staff and politicians. However, by 2006, there was a change in Chairperson as well as all the staff that had supported the group. This had a huge impact on the partnership and it came at a critical time, when the task force was about to embark on the implementation of the plan. So, active leadership is important to partnerships, but by 2006 the subject of drug policy making had
perhaps lost its popularity and with it, the leadership it required to be truly successful in the implementation of the policy.

**A focus on resolving conflict and consensus building**

One of the surprising insights into the workings of the SATF gained during the course of the interviews was the fact that the voting membership as well as the staff that worked to support the task force all indicated that there was very little conflict amongst the group during the course of developing the substance abuse policy. While most components of a four pillar drug strategy are fairly mundane (prevention, enforcement and treatment), the harm reduction pillar can be quite controversial. Though 'harm reduction' measures are varied, people tend to focus on two components of harm reduction, namely needle exchanges and safe injection sites. The debate about the legitimacy of these two approaches is heated and can polarize a group trying to achieve a balanced approach to drug policy making. Amazingly, the North Shore SATF had very little controversy about the harm reduction pillar. The following news article articulates the consensus achieved by the SATF around the issues:

It is not often that agreement is reached between North Shore Councils, let alone on an issue as potentially explosive as drug abuse. So, kudos to all involved for stick handling the North Shore Task Force on Substance Abuse into a position from which it may reach some important goals. To come to consensus and then obtain political approval from all three North Shore councils on an action plan that could include such things as a mobile needle exchange is truly quite remarkable. But the biggest news in this remarkable story is the shift in philosophical ground: the willingness to move towards a health-oriented, harm-reduction approach in dealing with the issues surrounding substance abuse.
The arguments for prevention, interception and treatment make sense financially, whether or not you agree with them on moral grounds. It is cheaper to intervene and treat an addict than to deal with the ongoing medical expenses of emergencies that are a likely outcome of any habit. The move should ultimately reduce policing and court costs too - at the very least, addicts with a support system are unlikely to steal for their needs. The first step on this road will be to assess what services we have in place and where the gaps and overlaps are. Thereafter, we will eagerly await implementation initiatives. (North Shore News, Op Ed, November 2001)

The possibility of a needle exchange did little to deter the membership of the SATF and by all accounts, there was very little push back from the public at all about the prospect of harm reduction. Members and staff reported that it was just understood that the four pillar approach, with all pillars being treated (and resourced) equally, was the best way forward.

Mark Bostwick, Social Planner, District of North Vancouver:
I would say that there were subtle divergences from among the larger SATF groups [i.e. from amongst the membership of the SATF]: West Vancouver School District was very active with its own plan and strategy—including developing a curriculum devised by police. The RCMP tended to be wary of the “harm reduction” and any idea of legalization (partly because the RCMP had a national policy). And there were perhaps some rivalries and professional differences between substance abuse agencies and parts of the Health Region. But, these differences did not lead to knock down/drag out battles.

At the SATF level Brian O'Connor and Craig Keating along with some of the other health officials were able to make the case for this health based approach. It is worth noting that MacKay-Dunn was a strong advocate of “drug courts” which provided a place for law enforcement to get behind the strategy. I would say that decisions were based on consensus with some doubters being quiet.

Councillor Bob Fearnley, City of North Vancouver
It [the four pillar model] was never controversial on the North Shore with the three Councils therefore it went forward without too much fanfare. We actually had
good advocates. Even conservatives in West Vancouver acknowledged there was a drug problem on the North Shore. Harm Reduction is not about facilitating drug use. I’m not ‘soft on crime’ – I want proven strategies that work. We can’t win a war on drugs – we need to manage the problem.

**Councillor Alison Morse, Bowen Island Municipality:**

Harm reduction was one of the things we recognized as important. There was not a lot of heated debate about this. Everyone recognized there was a problem. We needed to do it together even though there were organizations that did things differently.

**Larry Orr, Community Planner, City of North Vancouver:**

There were different perspectives on harm reduction and we were definitely influenced by Vancouver but it wasn’t controversial here on the North Shore. It’s actually amazing that it wasn’t a bigger issue for the task force. There was a fair amount of consensus in all of our discussions about the four pillar model. The municipalities were all very supportive. Brian [O’Connor] was the leader and he was very passionate about the issue. There was a feeling amongst the group that there was a responsibility to do something about it.

References to Dr. O’Connor throughout the interviews are worth mentioning here. There was unanimity that he brought leadership to the group and that he helped to build consensus when necessary so that the task force could move forward in developing the strategy. His role at the Medical Health Officer for the North Shore carried a lot of status and clout amongst the group, especially the elected officials. They listened to him and respected his opinion. The understanding that substance abuse was a health issue (as opposed to a moral issue) did much to bring the partnership together, to build consensus and ultimately assisted them in moving forward with developing the policy.
Good sharing of both knowledge and information

This area of Asthana et al’s partnership framework is the one that may provide the most insight into why the SATF had difficulty in implementing its plan. It appeared that there was a lot of consensus at the initial stages of the task force that sharing information and knowledge was important.

Dr. Brian O’Connor, Medical Health Officer, Vancouver Coastal Health:
We did look to other places – the US had several models that we looked at. We met with Don MacPherson [City of Vancouver Drug Policy Coordinator]- Mark and Larry and I – and established a ‘harm reduction’ rationale. We got ideas on strategies and what was successful from him. I also had access to a report from the Medical Health Officer [Provincial report]. It dealt with it as an illness. Vancouver was a great example of political leadership. Political leadership is absolutely necessary and critical to the success of this kind of initiative.

Mark Bostwick, Social Planner, District of North Vancouver:
The four pillar approach came from Vancouver. This was an initiative strongly supported by Mayor Owen in conjunction with local health officials. It was logical, therefore, that a similar approach should be adopted by neighbouring municipalities within the health region.

However, there were also differences that emerged in the approach taken by the North Shore that are worth noting. Many of the differences were based on what staff learned from their discussions with representatives in other cities such as Vancouver.

Mark Bostwick, Social Planner, District of North Vancouver:
The approach developed by the SATF responded to the distinctive features on the North Shore communities. In the end much of the “policy” parallels the Vancouver plan (i.e. four pillars) but how it came about was somewhat different. Differences include the fact that the North Shore is not a single municipality with one police force, one school district. On the North Shore the differences between these institutions needed to be accommodated. This even reaches down to the
staff level. The relationships between the three Social Planners and their respective bosses and Council varied considerably. This required careful collaboration between these staff members to find a common way to support the SATF.

Similarly there were differences in the communities: a greater proportion of middle, upper middle class residents; a very strong ratepayers influence, but a less strong (in contrast to Vancouver) community organizational base; a larger and more diverse on reserve native population. Vancouver has access to much greater resources and considerably more influence on provincial funding, programming, and policy. In addition, the City could appoint a single “go to” person for implementation (Macpherson). This, in itself, suggested that the North Shore would need to stick fairly close to Vancouver policies while adapting the process to local needs.

One of the ways that the North Shore managed to collaborate was by consciously overlapping networks. The Health Region approach to both substance abuse and homelessness was to bring together reps from those organizations who might in some way contribute to analyzing and finding solutions to a problem. Participants however did not stop with this level of collaboration, but returned to their organizations to create further network connections. Examples may include the way in which a number of parts of VCH ultimately became involved, or the way in which West Vancouver and the West Vancouver School District collaboration evolved.

The work to learn about other models, share information and knowledge and to develop a policy that achieved a North Shore specific content and feel did not stop at the city to city level. Much work was done by staff to consult with service providers and community stakeholders on their understandings and concerns about substance abuse. Mr. Bostwick’s example above of how participants in the SATF continued to collaborate outside of the SATF would be considered to be a successful outcome in Asthana et al’s framework for the evaluation of partnerships. By taking what they learned about working together beyond the mandate of the SATF, the member organizations managed to leverage these
partnerships and continue to do good work on other social policy issues across the North Shore.

**Mark Bostwick, Social Planner, District of North Vancouver:**
For many the “substance abuse problem” was primarily a “youth problem.” As such substance abuse was one of those issues debated by youth workers and educators. A growing number of people believed that young people were more sophisticated and skeptical than simple dummies to be filled like empty vessels with conventional wisdom. Thus, developing a strategy that encouraged thought and choice rather than simple docility became part of the SATF.

On the North Shore there was concern about seniors’ substance misuse of prescription drugs and also alcohol abuse, which had been identified by health agencies and community groups as a problem earlier in the 1990’s. Thus, seniors’ organizations did encourage attention to measures that would address this issue…and thereby broadened the base of support for the strategy. Similarly, the local first nations were concerned about substance abuse and illegal activities. Addressing these issues involved law enforcement and probably broadened the horizon of law enforcement people involved in developing the strategy.

There was obviously a lot of work done early on in the development of the substance abuse strategy to build knowledge amongst not only the group itself but the community as well. However, once the policy was adopted and it was time to implement that policy, the SATF no longer had a good understanding of the purpose and importance of either the task force itself or the policy it was meant to implement as the difficulties in implementation attest.

**Councillor Alison Morse, Bowen Island Municipality:**
The SATF is not a true partnership – we don’t have an autonomous authority to do things because we have to go back to our respective Councils with each significant decision. It’s more about building a common knowledge and sharing information so you’re not working at cross purposes to one another. Buying into a common plan (i.e. the four pillar model) was hugely important at the beginning. But to all the new people that joined the task force in 2006 this became less
relevant. We should go back to how we got to here. History is so important – need to know how we got here in order to move forward. Part of the problem is that we haven’t gone back to check in on the policy document for years. We need to do that to see if we made any progress.

To further complicate the challenges associated with implementation, the task force struggled with how best to include service providers, particularly non profit organizations (VCH staff were already part of the committee but were funders as well as service providers).

**Councillor Alison Morse, Bowen Island Municipality:**

*We fell apart with the implementation. Why? As elected officials, we’re not the ones ‘doing it’. Non profit organizations are better at this. The implementation is not actually in our control. But we didn’t include non profits as voting members because we were worried that they would only be there for their own vested interest. So we sent the information to them (e.g. minutes etc.) to try to ensure that they stay involved not just as observers – but it became a problem because they really weren’t part of the group.*

So, the sharing of knowledge and information had two flaws with the SATF. The first being that the membership of the task force was not regularly updated on the issues relevant to its work in developing and implementing a drug policy. The second was that the task force did not successfully share information with service providers who were ultimately responsible for implementing the plan once it was adopted. This failure to get buy in from the service providers and truly ensure that everyone was on the same page was perhaps one of the elements that led to the difficulties that task force had in implementing the policy.
Institutionalizing networks so that relationships continue irrespective of people that may come and go

The interview data reveals that, overall, there were good institutionalized networks established in order for the SATF to continue on as originally configured. The participation of the five North Shore municipalities, the two School Districts, the two police forces, Vancouver Coastal Health and the First Nations representatives continues to this day. Some of the faces have changed but the organizations are still represented around the table.

Larry Orr, Community Planner, City of North Vancouver:
Substance abuse affects everyone so it was truly a community issue. Was anyone missing? At first no, then we talked about who else should be there. The genesis of the idea was with a certain group and then it became bigger. We had the right people at the beginning. They provided a broad perspective which became important later on. There was commitment of the municipal Councils to the task force. There was accountability which was adopted by the elected officials - then the system works. In this case the top down approach was very effective. The North Shore Congress was also important - they told us to do it, we didn’t need to convince them. We needed to elevate the issue to higher levels and the North Shore Congress was the best place to do that.

Dr. Brian O'Connor, Medical Health Officer, Vancouver Coastal Health:
The origins of the SATF came from the North Shore Congress with the main push from the municipalities – specifically the Social Planners and the Medical Health Officer. Was anyone missing? It was the view and vision of the Medical Health Officer – it was not ever about program planning – it was about political leadership and ownership of an issue. Policy options to deal with substance abuse needed to be put in place. It became an important issue in the community as well – from the beginning it was an important issue for residents. Everyone was on side. It was an important issue, and not just about enforcement (i.e. the traditional approach). There was community responsibility and ownership and a feeling that we must develop a strategy. There was no internal opposition. We went to great lengths to get the message across – was seen to be an illness and about health. There was good synergy about this issue.
It appears that the institutional structure set up by the task force at the outset was ideal for developing a potentially controversial drug policy for the community, but was ineffective when it came to implementing that policy. It's clear that the political membership was critical for "stick handling" the development of the policy and the resulting community consultation process. However, there were insufficient networks established amongst the service providers involved in delivering programs, services and supports for substance abuse in the community to sufficiently implement the policy. Therefore the existing network of members, and the strongest supporters of the process, the municipalities, began to realize that they weren't the right people to see the project through to implementation. The problem was that those that were did not belong to the institution and were therefore apparently not able or willing to assist in this regard.

**Councillor Alison Morse, Bowen Island Municipality:**
There is not a lot the municipalities are directly responsible for that gets you into the implementation. Question is what is our role? We're currently meeting for meetings sake. We should really only meet X1 per year. Prevention costs more and you need to do that up front. Were we successful? Initially yes, but the last few years no. We haven't managed to get any further. Other than youth outreach services the municipalities don't have much to do with substance abuse. We fell apart with the implementation. Why? As elected officials, we're not the ones 'doing it'. Non profits are better at this because implementation is not in our control.

The debate about the municipal role and jurisdiction with regards to the implementation of a substance abuse policy is complex. The North Shore has a long history of municipal support for social policy creation and implementation,
including a well resourced social planning staff group as compared to other cities\textsuperscript{6}. Municipal Councils on the North Shore also have a long history of supporting social policy initiatives brought forward either by staff or by community partners. These include well funded municipal youth outreach programs, a well funded community grants program across the North Shore, support for and funding and facilities for homelessness, and generous permissive tax exemptions for social service providers. However, there are a few specific areas of policy work the North Shore municipalities do not consider to be within their jurisdiction. These include things such as capital and operational funding of childcare services, any employment programs for youth and adults etc. Substance abuse services have also been considered a provincial mandate, particularly those in the treatment and harm reduction categories such as direct substance abuse counseling services, needle exchanges and detox and rehabilitation / treatment services. Though the municipalities appear interested in assisting in the development of policy, and being part of the SATF, the implementation of the treatment and harm reduction pillars are considered to be the jurisdiction of the provincial government.

\textsuperscript{6} The City of North Vancouver and the District of North Vancouver each have 3 FTE’s of social planning staff. The District of West Vancouver has only one, but it is a management position. Other municipalities with a similar or greater population such as Coquitlam, Port Moody and even the City of Surrey, often have only one social planning staff person who usually must also do land use policy planning.
Accountability of all partners for their decisions and actions

The last component of the partnership framework outlined by Asthana et al is about accountability. Regardless of the ability of a partnership to secure staff support, to create and maintain leadership or to achieve consensus, the ability for a partnership to achieve true accountability is a critical part of its success.

What’s interesting in the data collected during the interview process for this research project is that the perception of ‘successful’ accountability differed between the voting membership (the politicians primarily) and the staff working to support the task force. The following excerpts from two interviews articulate the perspectives of staff well:

Dr. Brian O’Connor, Medical Health Officer, Vancouver Coastal Health:
Accountability did definitely go beyond ‘the people’. Membership was by appointment for the School District and for the municipalities. Reporting out at the North Shore Congress also led to accountability. It was not person dependent – if one person left another from that organization joined. There was a requirement to replace a person if they left. People wanted to be there – Councillor Keating really wanted to be the Chair – people felt that it was important. The politicians anointed someone to go. Barb Charlie [Squamish Nation] was a true Elder and an excellent leader – she was very committed. There was organizational accountability from top to bottom. There was political leadership from the top.

Mark Bostwick, Social Planner, District of North Vancouver:
I think there is something called ‘interlocking accountability’ in which an individual participates partly because he or she wants do, partly because he or she has either asked or been delegated by a superior to participate, partly because of professional considerations (being part of an important activity), partly because the institution to which one belongs is scrutinized by other institutions (e.g. by the police department, by municipal Council), and partly to protect institutional interests. Clearly it was a tacit responsibility of the more active members of the SATF to try to make it worth while to attend SATF meetings...the
moral authority of someone like Brian O’Connor was obviously very important. And the participation of Council members certainly encouraged others to attend.

However, politicians had a more cynical view regarding accountability. While they concurred with the staff perspective that members were required to join, they had more to say about the motivations people had to joining the task force in the first place.

**Councillor Doug MacKay-Dunn, District of North Vancouver:**
The bosses attended the meetings – it was about turf protection – they wanted to make sure that they didn’t get screwed, that’s why they went.

**Councillor Alison Morse, Bowen Island Municipality:**
I would say “no” to the question of whether or not I would be replaced if I left the task force. It is definitely a personal interest of mine. Bowen Island doesn’t have Councillors on all its committees therefore the SATF would be at risk of not having one if I left. We have some unique circumstances with regards to drug abuse and additions because we’re an island, that’s why I hang in there. But if I didn’t go, I don’t know who would.

Regarding the work output achieved by the task force, the feedback was also more critical than that of the staff during the course of the interviews.

**Councillor Doug MacKay-Dunn, District of North Vancouver:**
There was a lot of discussion about a lot of things – there was a lot of process. My approach was more action oriented. I wanted to find out the answer. As a former police officer I wanted to find out “who did this and put them in jail”. There was too much process with the SATF. They made a meal out of an apple. We spent a lot of money on process and then the process became the implementation. Where was the accountability in that? It would have been more successful if we could have had a detox and rehabilitation centre, then it would have been a huge success. We needed to start there and then works backwards – from those in crisis to those that needed ‘prevention’. Why didn’t it happen? Because of NIMBY [not in my back yard]. Basically there was no consensus on which municipality would take it (i.e. the location of a detox and rehab) on.
The remarks made by Councillor MacKay Dunn provide insight into the challenges faced by the SATF. While the work involved in creating the policy was complex and required the active participation of all the members, the end goal was clear: to develop a substance abuse policy. According to this member, it appears that the process undertaken to develop the policy was lengthy and perhaps a bit complicated. Unfortunately, the process did not make it clear how some of the policy details would be implemented and even after much discussion, according to this member, there was no consensus on key components of the implementation of the policy. It’s one thing to have a policy that is highly lauded and speaks to the participation of all members regardless of their varying political affiliations, but the implementation of the policy, particularly key components that would be very difficult to achieve such as a detox or rehabilitation centre, were left out of the discussions of this group.

**Conclusions and Areas for Further Research**

The partnership framework developed by Asthana et al. provides a useful tool to explore both the style and form of specific partnerships as well as provide some insight into the successes and failures of the partnerships. The eight components of their framework and how the SATF performs in each has been the main thrust of this research project. The intended outcome was to be able to describe the SATF and to provide some insight into whether or not the way in
which the North Shore chose to address substance abuse was particularly unique and therefore successful in tackling this complex social problem.

The following will provide some concluding remarks for each of the eight components of Asthana et al’s framework as they relate to the SATF, will comment on the current status of the SATF and how the characteristics of the partnership affected the implementation of the policy and finally, will provide some suggestions for further research on the topic of partnership making and social policy.

**Funding for the Administration of the Partnership**

Funding is a key component of Asthana et al’s partnership framework. As can be seen from the input provided by the lead staff assigned to support the SATF, the work involved in the administration of the partnership was not insignificant. It is important to note that two types of support were needed. One was traditional administrative support by way of minute taking, agenda circulation, management of the listserv associated with the membership, meeting and consultation space bookings, and so on. The second kind of administration had to do with the ‘work between meetings’ that consisted of agenda development, review of minutes before they went out to the membership, development of action items associated with the work of the task force such as the development of a work plan, the development of the terms of reference, the work associated with taking discussion items that form action items from the task force to fruition, and so on.
So, in addition to the secretarial support provided to the SATF by the City of North Vancouver Clerk’s department, the SATF also supported the idea of using municipal social planning staff time to support the work associated with moving the task force along. At times this also included the hiring of consultants, which staff were required to guide and supervise. So, the SATF did in fact provide the necessary funding for the administration of the partnership. Municipal and provincial (Vancouver Coastal Health) facilitated annual budget contributions to the task force were significant to the overall success of the task force. This was facilitated by a funding formula developed by staff that saw contributions match the relative populations of the municipalities. Though the contributions were not equitable (for example, Bowen Island did not contribute due to its size and limited budget for this kind of work), there was a sense of satisfaction amongst those interviewed about the funding in place for the administration of the partnership.

In fact, the 2010 SATF continues to be in a very good financial standing, with $54,000 in its earmarked account for work associated with substance abuse in the community. The irony is that the current SATF struggles to figure out what to spend the money on. As a result of the generous amount of money ‘in the bank’ for this task force, the municipal budget lines for the task force were lost in 2009. It was difficult for staff and the relevant politicians to argue that their budget lines for this task force should be kept when there was so much money in existing accounts and no work plan with any associated costs to spend the money on.
So, the funding for the administration of the partnership for the SATF has been in place since the beginning of the work of the group and has achieved the key outcome of supporting the overall administration of the work associated with the task force. Ironically, the struggle today is on how to spend the funds.

**Based on Need**

A second key component of Asthana et al’s partnership framework is that the partnership come together based on an identified need. In the case of the SATF there did appear to be a consensus amongst the group that a substance abuse policy was necessary. The North Shore was not alone in feeling the need to respond to what many felt was a crisis of community with regards to overdose deaths and disease spread associated with drug use. Work in other municipalities both locally and internationally (Vancouver and Zurich as examples), as well as in the Lower Mainland region (the LMMA as an example), around developing a policy response to substance abuse issues was well underway by 2000. However, the sensational headlines around the world and even locally, and the urgent political atmosphere to ‘do something about substance abuse’ was not necessarily hard evidence.

A review of the secondary data associated with the SATF did not reveal any thorough analysis of the severity or the extent of the substance abuse problem
on the North Shore. By contrast, the work done in the City of Vancouver had not only end user evidence (provided by the Vancouver Area Network of Drug Users – VANDU) but it also benefited from numerous academic studies of the substance abuse situation in the city as well as gap and needs analysis about the services available (and by default those not available) for those addicted in the city. The North Shore did not embark on a full needs assessment of the substance abuse situation on the North Shore and did not do the work necessary at the beginning of its process to be clear about what services were currently being provided and by whom and what would be required to be changed, added, and enhanced in the development and implementation of the anticipated drug policy response to the alcohol and drug issues in the community. Pressman and Wildavsky articulate the need to consider implementation as an integral component of policy development. It appears that the SATF did not do this. If they would have, the need to do an inventory and gap analysis of existing programs to address substance abuse in the community would have surely been done. The rationale would have been that, in order to affect change, the SATF would need to determine a benchmark of services and supports available to the community for substance abuse, and that the policy would address the gaps in those services in order to facilitate better outcomes overall. Without this benchmarking work, and a full analysis of the need in the community as it relates to substance abuse services and supports, the SATF had no clear way forward when it came to the implementation of the policy.
Supports are in place with dedicated staff

The need for funding to support the administration of the partnership is closely linked to the need to have dedicated staff in place to support the work of the partnership. The SATF did have dedicated staff support through the municipal social planning departments and of course the Medical Health Officer and those staff did appear to be committed and very interested in the work of the task force, particularly in its early days of policy development. One politician interviewed even made the suggestion that the topic of substance abuse and the way cities organized to address it was a great way for civil servants to make a name for themselves and was a great career builder. The profile of the SATF on the North Shore specifically was high. It was made up of elected officials from across the North Shore and as a result, became an important committee for staff to attend. The role of staff support was given to the senior social planning staff in each municipality. These staff were the ones that had years of experience and that already had profile amongst the elected officials around the table.

In addition to the support of existing staff from across the North Shore, the SATF regularly hired consultants to do work for the committee. Overall there appeared to be a consensus that the work provided to the task force by these consultants was satisfactory. The municipal staff felt that the assistance of the consultants was necessary to get the work done in a timely manner and to take the pressure off of them since they had their regular jobs to do.
The North Shore Substance Abuse Task Force

The task force eventually hired a coordinator as a way to handle the work load. The coordinator was paid by the funds collected from the municipalities for the committee and was overseen by the original staff group for the task force. However, the model didn’t seem to work well. There were likely several factors that impacted the ability of the coordinator to do her work successfully. The first and most important was the fact that her work plan, which was the implementation of the substance abuse policy, was not very clear or well thought out. It basically became a communications position, with the coordinator circulating information regarding substance abuse work being done in the community by other (more front line) organizations. The second challenge was that, as stated earlier in this research project, all the key staff left the committee by 2006. So, the coordinator had no oversight for several months as new staff were put into place, and then the new staff were not provided with a clear description of what the coordinator was supposed to be doing. The coordinator was eventually let go and the work of the task force was once again supported by the municipal staff leads.

So, the focus on staff supports outlined by Asthana et al. is a particularly important component in the analysis of the SATF. The work provided by staff to support the task force had a significant impact on the overall success of the group. When the key staff all left in 2006, the task force appeared to lose its
way. Of particular interest is the departure of the Medical Health Officer. While he considered himself to be a regular staff support person to the task force, the task force membership all commented (as did the other staff interviewed) about the important role that he played. His professional reputation as well as the respect that he brought with him as the Medical Health Officer had a big impact on the task force. Though he replaced himself with a Director of Mental Health and Addictions from Vancouver Coastal Health, the task force never really bought into this trade as an equal trade of staff. The director did not have the same profile in the community.

**Active leadership**

The existence of active leadership is a third component of Asthana et al's partnership framework. They outline the need for active leadership amongst the group as an important indicator of success. The SATF had good leadership, particularly in the early days of policy development. The task force was a prestigious group, and the role of Chair was given first to a Councillor from the City of North Vancouver and then to the Mayor of West Vancouver. It now rests with a Councillor from the District of North Vancouver. The membership also appeared to be very invested in the early work of the task force, with full membership at meetings and work done by the membership between meetings to move the development of the policy along.
However, the change over in staff supports in 2006 described above was followed by a change over of the voting membership in 2007/2008. Both the City of North Vancouver and the District of West Vancouver voting members stepped down and/or were not re-elected and new elected officials took their place. This resulted in a gap of knowledge amongst the group and the need to revisit why they were there, and what they were supposed to be doing. There appeared to be lack of understanding about the purpose of the group, which was in part because the continuity of the membership had changed and the new leaders weren’t clear on the mandate of the task force.

So, while active leadership is important, it is almost impossible to move into active leadership when some members aren’t clear even about the purpose of the group. While there were still some members that had been there from the beginning, the new members needed to be brought up to date and no significant work could be done by the veteran active leaders until everyone was bought in. The other challenge was the issue of implementation of the policy developed by the task force. While it appears that during the first several years of the task force the voting members (and leaders) knew very well what work needed to be done. That is, to develop a substance abuse policy. The clarity of the work plan in the first years of the task force provided a great opportunity for all the voting members as well as the staff to be leaders and to advocate and work hard to get the job done. However, with little or no description on how the substance abuse
policy was to be implemented, when the time came to do this critical step, no one really knew what to do. Leadership in this kind of uncertainty is much harder to achieve because the consensus of how to move forward isn’t clear.

Focus on resolving conflict and consensus building

Dealing with conflict in a group can be difficult and Asthana et al. discuss the need for a group to consider how to handle conflict and to also consider what the approach toward a consensus based decision making might be. Considered by Asthana et al. to be an important part of the process of partnership working, the ability to resolve conflict (and to create a partnership framework that allows differences to be easily shared) is very important. The challenge, according to Asthana et al., is that “partnership meetings may not be the right fora to express strong differences of opinion. Strategic players have certainly become adept at using the rhetoric of partnership and demonstrate a willingness to align decisions. However, despite statements of support, it can take considerable time to make decisions about critical issues” (Asthana et al, p.789, 2002).

Though the research done for this project revealed very little evidence of conflict amongst the group about the content of the substance abuse strategy, there is one worth noting which is what to do about harm reduction. While harm reduction can include a wide range of services and supports for addicts, the most controversial is usually the siting of detox and rehabilitation facilities and needle
The North Shore Substance Abuse Task Force

exchanges (and in Vancouver of course it was the decision to create a safe injection site, but this was never considered to be necessary on the North Shore and as a result, was not discussed). It is interesting to note that very little evidence was found in the secondary data related to the debate about the potential of future detox and rehabilitation facilities. The differences of opinion on this were only revealed as part of the interview process whereby individual members recollected a sense of disagreement about it. It was not about whether or not a detox and rehabilitation facility was needed but rather which municipality would accommodate it.

In the early days of the task force, the issue of homelessness and the lack of emergency shelters for youth and adults were also on the radar and a North Shore Homelessness Task Force was created to deal with these issues. Social planning staff recollected that an informal agreement (i.e. not endorsed by Council or in any formal way) was made that the City of North Vancouver would work on creating an adult homeless shelter, the District of North Vancouver would work on creating a youth homeless shelter and that the District of West Vancouver would be responsible for siting a detox and rehabilitation facility within its municipality. The shelter beds for youth and adults in the two North Vancouver's did get built, however, the detox facility never materialized. The only evidence in the data to suggest any real efforts on the part on the SATF to develop a detox and rehabilitation facility came in 2006, when the Squamish First
The North Shore Substance Abuse Task Force

Nation basically offered their land for this purpose. The SATF created a subcommittee to explore the possibility and to create a business case for it to present to funders (which would primarily be Vancouver Coastal Health).

Unfortunately, the capital and operating funds for bringing this project to fruition never materialized and the SATF had to drop the idea altogether. Part of the rationale for dropping it also appeared to be the opening of the Burnaby Centre for Mental Health and Addictions in 2007 which the SATF felt did add beds for those in need and may have addressed the problem.

The fact that the SATF was not successful in creating a detox and rehabilitation facility did irritate some of the members as can be seen in the analysis section of this research project. When the task force was creating the policy, harm reduction was included but there was no substantive discussion about how it would be addressed and where a facility for detox and rehabilitation would be built. While a few members recollected some tensions, the general consensus was that harm reduction was an important part of the strategy and if there was agreement about that, it would be part of the strategy.

The SATF really has always worked on a consensus based decision making model whereby all members need to agree before moving forward. I think there was agreement about including harm reduction generally in the strategy, however, when it came to implement part of the harm reduction pillar (i.e. a detox
and rehabilitation facility), the expected political struggles took place and this was never achieved. However, whether this was because of the differences in opinion about the location of such a controversial facility or whether it was because the SATF had lost its profile and its sense of urgency is difficult to determine.

**Sharing of both knowledge and information**

The analysis section of this research project indicates two areas where the SATF fell apart with regards to the sharing of information and knowledge, which is an important part of Asthana et al's partnership framework. However, these had primarily to do with the implementation of the policy. The first was the creation of a mechanism for the SATF to be regularly updated about relevant and pertinent information related to substance abuse policy. The SATF did a good job sharing information and knowledge as they worked toward creating the policy itself. There was consultation with other policy makers, particularly the City of Vancouver staff leading the process there. However, this work was really only done at the beginning of the process. There didn’t appear to be any further meetings and/or research done once the substance abuse strategy was completed. On going meetings may have revealed some best practice approaches to substance abuse policy implementation that could have been used by the North Shore.
The second challenge was the connection the SATF has with the service provider community on the North Shore. There was a sharing of information and a request for knowledge from service providers (and the public) around what kinds of services existed on the North Shore for substance abuse and what was needed (and what would be acceptable to the public). But again, the sharing of knowledge and information on how to implement the strategy once completed was lacking. There was no real structure for the front line service providers to be involved in the task force. If they were invited to attend, it was as non voting members, effectively guests of the SATF. This lack of any kind of formal role for the service providers with the task force created very real challenges for the group when it came to implementing their policy. By 2006 the service provider community likely had forgotten the SATF even existed and any meaningful connection between the ‘doers’ and the ‘decision makers’ was lost.

So, Asthana et al. articulate the need for the sharing of information and knowledge, which is important. But perhaps it is even more important for groups to formalize how information and knowledge will be shared and how those sharing it are expected to work together. However, it’s not enough to just share information and knowledge. Partnerships must create meaningful and collaborative ways in which the knowledge shared and gained can be put to good use, otherwise decisions are made in a vacuum and successful implementation may be fleeting.
**Institutionalizing networks**

It is of critical importance for any partnership to have a structure in place to address how organizations, not just the individuals that work for them, are to interact with the partnership. That is to say that, it is the organization that is most important as far as the sustainability of the partnership goes. This recognizes the reality that people do come and go to partnerships and that in order to be able to maintain a work plan and to continue toward the goal originally set out by the group, it is critical to ensure that the representation of the organizations and networks that make up the partnership remain. This has posed a challenge for the SATF. The terms of reference articulate very specifically which organizations are members of the task force, however, there are two challenges with the current approach.

The first challenge was that the SATF was meant to be a task force of elected officials and key senior staff (some of which who were not voting members but required to be there to support their respective elected officials). Over the years there has been consistent representation assigned to the task force, including changes of membership because of municipal elections, and when some members decided to move on to other committees. Unfortunately, this component of the partnerships framework set out by Asthana et al. does not account for the importance of personalities in creating successful partnerships. Of course it is very important to ensure continuity in a partnership and to find a
way for organizations to stay committed to the work of the group, but requiring organizations to send a staff or elected official just isn’t enough. The loss of key staff in 2006, coupled with a sense of aimlessness on the part of the committee as a whole, had devastating effects on the work of the SATF and made it almost impossible to continue in any meaningful way.

The second challenge the SATF had with achieving institutionalized networks is that the membership has not even included those staff whose mandate it is to implement the actions found in the strategy. It could be argued that the School Trustees could require their teaching staff to implement parts of the strategy (the prevention pillar seems most logical) and that the municipal Councillors could do the same for the enforcement pillar (via the police departments which they fund) and parts of the prevention pillar (through core funded agencies that receive municipal grants) and that the Vancouver Coastal Health representative could ask their staff to implement the harm reduction and treatment pillars of the strategy. The reality is that those people also needed to be at the table, and needed to have been involved in the creation of the SATF, in order to be at all loyal or even interested in the work related to the implementation of the policy. Asthana et al. discuss this challenge by saying that “there is evidence of the strengthening of networks between strategic actors and between frontline agencies and staff, but the forging of links between different levels of the service hierarchy remains more problematic” (Asthana et al., p. 790, 2022). While on
paper it appears that the SATF had everything going for it with such high powered decision makers as key leaders on the committee, and a way to ensure that their organizations continued to be represented, the reality is that the structure allowed very little ability for the task force to successfully implement the strategy because the people that needed to know about it didn’t, and probably didn’t really care.

**Accountability**

The accountability of the SATF must be examined via a few different points. It is clear that the organizations that were voting members of the SATF were accountable to the SATF in many ways. This included the formalities associated with an approved policy. The organizations were committed to sending representatives to the SATF, they were committed financially and for years had budget lines associated with the SATF. Staff were assigned to provide support to the SATF. These are all important components of this part of the partnership framework provided by Asthana et al. However, also well articulated by Asthana et al is that, “despite the policy push behind the development of partnerships, little thought has been given to how to develop formal accountability relationships with other stakeholder groups such as partner agencies, professional groups and employees” (Asthana et al, p. 790, 2002).

The SATF did not anticipate that the membership of elected officials and key senior staff from health and the police departments would not (and maybe could
not) get the buy in from their staff necessary to continue the work of the SATF once the policy was adopted. Either the SATF just didn’t think far enough ahead, or they felt, naively I would argue, that their considerable positions of power within their own organizations would result in activity related to the implementation of the SATF beyond their individual participation. As it turns out, those organizations providing front line substance abuse services across the North Shore did not have anything vested in the SATF that would result in their prioritizing the policy once adopted and setting to work to implement its key actions. And the accountability that the voting members organizations had to continue to participate in the SATF did not address the challenges associated with what to do with the policy once it was created. So, the members, true to the terms of reference, continued to attend, but had very little tangible success beyond the creation and adoption of the substance abuse policy itself.

**Representation**

Though representation is not a component of Asthana et al.’s partnership framework, it is particularly important and worth noting here. The SATF may have made a tactical error by not involving the non profit sector directly in the work of the task force. Though the non profit agencies on the North Shore working with substance abuse clients were consulted at particular stages of the policy making process, they were not (and continue not to be), direct voting members of the SATF. The primary membership (all those except Vancouver Coastal Health) is comprised of elected government officials. The literature
discussed the prevalence of small groups of elite local actors in those partnerships that were lacking in a diverse representation of members. The SATF appears to be such a partnership, with very little meaningful collaboration with local service providers. While the creation of a North Shore Substance Abuse Policy was possible without directly involving the non profit sector, the implementation of the policy once adopted by the municipalities was much more difficult because it was primarily these front line service providers that would need to do the work related to implementation. The interviews done for this research project indicate that some of the municipal members of the SATF did not feel that they were responsible for implementation. This begs the question then whether those that were responsible knew or even cared about the policy the SATF created. Without them, the move from policy making to policy action was almost impossible.

Policy Transfer

The extent to which the North Shore’s policy makers modelled the North Shore’s Substance Abuse Strategy after similar policies in other city’s such as Zurich or Vancouver is unclear. While it is true that planning staff did go to Vancouver to meet with Vancouver’s policy planners to discuss that city’s substance abuse policy, and that at the same time as those meetings were taking place, Vancouver staff had just returned from similar policy sharing meetings in Europe, the tacit acknowledgment that they were engaged in policy transfer is not
obvious. The interviewees did speak to their experiences and associations with Vancouver city staff in their early efforts to develop a drug policy framework for the North Shore, but they stopped short of any acknowledgment that this was a conscientious part of their process. This seems to support some of the arguments made in the literature review section of this paper that this kind of knowledge transfer was just a business as usual approach for the planning staff. The Vancouver experience with drug policy had garnered widespread media attention, as had the impact of drug addiction on various Vancouver neighbourhoods, so it was obvious to all the planners interviewed that a meeting with Vancouver planners should be part of the process. Similarly, the North Shore participated in the Lower Mainland Municipal Association's drug policy planning process, but ultimately, they moved ahead without copying either the LMMA's process or the Vancouver model verbatim. What is interesting is that the North Shore decided to do this as a group of municipalities. That is to say that, even though the North Shore didn't particularly identify with a policy transfer approach with the City of Vancouver, all those interviewed felt that the five municipalities that make up the North Shore needed to do this work together.

The City of North Vancouver and the District of North Vancouver led this process willingly and used the strength in numbers approach to drug policy making to their advantage. That is, it was much easier to tackle this problem across the North Shore than to do it in isolation. That could be described as a kind of policy
transfer when considering a small municipality such as Bowen Island, who, though a willing participant in the North Shore's drug policy making efforts, would likely not have done anything like it if it were not for the other municipalities taking the lead.

Current Status
The SATF has very recently made a change to its meeting process. It is now moving to a Standing Committee format whereby the task force meets only once annually or at the call of the membership if an issue arises that a member feels the task force should address. In addition to the change in meeting frequency from quarterly to once annually, the task force has also created an opportunity to share information and to vote on issues electronically via a SATF electronic newsletter that will be circulated three times per year. As has been described in this research project, the SATF has struggled in the past several years with regards to its mandate and purpose. The membership came to the conclusion (with the assistance of staff who proposed the standing committee model) that the work of the committee should be advocacy, collaboration and leadership, which is as its described in their terms of reference, and that the implementation of the substance abuse policy is being carried out by other, more front line based committees across the North Shore. To this end, the membership agreed that meeting less frequently and coming together on an as needed basis is the best way forward.
It’s interesting to note that this recent change could have prompted the membership to disband all together. This is in fact did come up at a meeting in January 2010. However, the membership continues to feel that the SATF is an important group and that disbanding is not an option. So, the group continues to exist and is poised to respond to issues related to substance abuse in the community on an as needed basis. The work of implementing the substance abuse policy has been left to the non profit organizations and Vancouver Coastal Health front line staff to implement in a decentralized manner, which appears to be working quite well.

The most active group is a committee called the Action on Prevention committee which includes staff from all of the political members of the task force and has an active work plan that focuses on substance abuse service enhancements, prevention initiatives for teens, education workshops for parents and harm reduction projects for the community. Also interesting to note, Vancouver Coastal Health quietly opened the first needle exchange on the North Shore in September 2010 (unbeknownst to the SATF) and has apparently been successful in securing both funding and a location for this controversial service.

So the work outlined in the North Shore’s substance abuse policy is being implemented by other groups in a fragmented way but apparently successfully. The SATF should have considered how it was going to implement the policy it
created in a more thorough manner early on and should have incorporated this plan into the policy itself. However, the truth is that the development of the policy itself, particularly with such a diverse and political group, is a true testament to the strength of the partnership and to the desire to address substance abuse in the community.

Further Research
The scope of this research paper does not provide for a full examination of how cities turn policy making into policy implementation. Implementation is, however, a critical part of policy making. Without it, change doesn’t happen, issues are not addressed and problems persist. The SATF is a complex partnership with several cities involved, a health organization that went through (and continues to go through) significant organizational changes, two First Nations groups, two School Districts and two police forces, one municipal (West Van Police) and one national (the RCMP). The complexity of the partnership provides some insight into why the group struggled with the implementation of the substance abuse policy but more work needs to be done to uncover whether or not the organizational complexity of partnerships leads to specific challenges with implementation.

An additional area of research may be why some policies are shared and why some are not? McCann argues that even policy mobilities are structured hierarchically. That is to say that, some policies are more popular than others but
some policies are also better able to ‘travel’ than others and some places are better able to go find these policies than others (McCann, SFU lecture, October 2010). The drug policies organized around the four pillar approach have seen duplication around the world, from Australia, to Switzerland, to Germany to the US, and finally to Canada in both Vancouver and to the North Shore. While the uptake and implementation varies around the world, the four pillar structure is relatively the same in all of these countries. But why is it that this kind of policy gains so much international attention when others don’t? And why don’t all other cities that have drug issues adopt a similar approach? More research needs to be done to uncover why and how some policies are more mobile than others and what impact the hierarchy of policy mobility may have on this process.

Finally, the impact on cities of a public health perspective is an interesting area of research that should be explored further. This research paper articulated the influence of and respect for the North Shore’s Medical Health Officer as being a critical part of the successful adoption of the substance abuse strategy. The argument that social ills such as drug addiction and homelessness are a health issue appears to allow municipality’s greater leverage with the public to address them appropriately. There was very little public outcry about the North Shore’s four pillar drug strategy, and in part it was because the elected officials could stand in front of the public and argue that the issues were not moral or ethical, but rather medical and that they required immediate attention. This appeared to
be more palatable to the public and allowed the politicians to take a stand that was safe politically. More research should be done to explore the public health agenda and its impact and importance on urban political geography.
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Appendix

North Shore Substance Abuse Strategy
North Shore Task Force on Substance Abuse

North Shore Substance Abuse Strategy

February 14, 2002

- City of North Vancouver
- District of North Vancouver
- District of West Vancouver
- Bowen Island Municipality
- Village of Lions Bay
- North Shore Health Region
- North Vancouver School District (No. 44)
- West Vancouver School District (No. 45)
- Squamish Nation
- Tsleil-Waututh Nation
Credits

This Strategy would not have been possible without the assistance of a number of individuals:

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Kirk & Co. Consulting Ltd.  
Draft Strategy Facilitation

Donald Golob  
Donald Golob Consulting  
Public Meeting Facilitation

Lorraine Sissons  
City of North Vancouver  
Strategy Layout and Design
# Table of Contents

Message from the Chair .................................................................3
Message from the North Shore Task Force on Substance Abuse ............5
List of Task Force Members ................................................................6

1. Executive Summary .....................................................................8

2. Stories ..................................................................................15

3. Introduction ..............................................................................18
   3.1 North Shore Task Force on Substance Abuse .........................20
   3.2 Making of the Strategy .........................................................22

4. Background ............................................................................24
   4.1 North Shore Illicit Substance Crime Statistics .......................26
   4.2 North Shore Priorities .........................................................26
   4.3 The Regional, National and International Context ...............30
   4.4 Emerging Key Themes from Related Reports and Policy Documents in the Lower Mainland .........................31

5. Evolution of the Four-Pillar Approach .......................................36
   5.1 Prevention ........................................................................36
   5.2 Treatment ..........................................................................38
   5.3 Enforcement ......................................................................40
   5.4 Harm Reduction ...................................................................43

6. North Shore Goals .....................................................................45

7. North Shore Actions ..................................................................47
   7.1 Prevention ........................................................................47
   7.2 Treatment ..........................................................................50
   7.3 Enforcement ......................................................................52
   7.4 Harm Reduction ...................................................................53

8. Implementation ........................................................................56
   8.1 Implementation Structure ..................................................56
   8.2 Monitoring and Evaluation ................................................58

9. Conclusion ..................................................................................59

10. Glossary ..................................................................................60

11. References ..............................................................................71
Message from the Chair

On the North Shore, as in other communities across Canada, substance abuse has come into focus as a major and complex health, safety, social, and economic issue. It is something that deprives those whom it afflicts, as well as those closest to them, of both their health and social and economic security. Its consequences and the often violent underground world that makes some forms of substance abuse possible, erodes our individual and our community’s sense of peace and well being.

Acting on this awareness of its manifold causes and consequences and in response to the seeming failure of traditional approaches to it, the North Shore Congress (an informal grouping of elected and appointed officials of the Municipalities of Bowen Island, the Village of Lions Bay, the District of West Vancouver; the District of North Vancouver, the City of North Vancouver, the Squamish First Nation, the Tsleil Waututh First Nation, School District #45 (West Vancouver), School District #44 (North Vancouver), the North Shore Health Region, Vancouver Port Corporation and the Board of Capilano College) established a task force in October 2000 to devise a strategic response to substance abuse in our community.

The Strategy you have before you is the result of a year of hard work by Task Force members and by support staff from member organizations of the North Shore Congress and includes the results of public consultations on a Draft Strategy.

The Strategy’s fundamental point of departure (and the one according to which any and all of its specific proposed actions can be referred) is that substance abuse is not primarily a moral or a criminal issue but a health issue. Accordingly, the Task Force has chosen to adopt the so-called “four pillar approach” that has proven its success in cities in the US and Europe. This approach addresses the medical causes and consequences of substance abuse in their fullest sense, seeking to integrate Prevention, Treatment, Enforcement, and Harm Reduction as the essential variables of the problem. As governments everywhere attempt to catch up to public opinion on how to tackle substance abuse, Task Force members look to the public to find out what we have left out as specific actions within this approach.
The development of a strategy is but a first step in tackling the problem of substance abuse on the North Shore. The tougher task of its implementation lies ahead. Looking forward to this, the Strategy places emphasis on actions that can readily be achieved by the Task Force's member organizations. It also anticipates co-operation and co-ordination of activities with other jurisdictions around the Lower Mainland as well as with the federal and provincial governments.

The commitment and co-operation of virtually all public decision making bodies on the North Shore is itself unprecedented. It certainly speaks to the seriousness of the issue of substance abuse in our communities. But it also speaks to the possibility of collective action by our diverse jurisdictions in tackling this and other social and economic issues of common concern in the future. On behalf of the Task Force I invite you to read this Strategy, to become involved in discussions around it, and to help us in the work of building a safe and healthy community for all.

Councillor Craig Keating, City of North Vancouver
Chair,
North Shore Task Force on Substance Abuse
Message from the North Shore Task Force on Substance Abuse

Substance abuse affects the health and safety of our North Shore communities. Understanding that substance abuse is like many other chronic illnesses and is caused by various health and environmental factors can help us determine how best to manage substance abuse on the North Shore.

The North Shore Task Force on Substance Abuse has been working with many sectors to develop a North Shore Substance Abuse Strategy based on the four pillars of prevention, treatment, enforcement and harm reduction. This strategy benefits from and complements other substance abuse policies throughout the Lower Mainland, while emphasizing the unique needs of North Shore communities.

In addition to dramatic human consequences, the costs associated with substance abuse and the criminal justice system are staggering. The substance abuse resources currently targeted toward the criminal justice system could more effectively be used by providing coordinated programs and services that work toward creating safer and healthier communities for everyone affected by substance abuse.

The North Shore has an important local role to play in further developing and implementing a comprehensive substance abuse strategy. In addition to North Shore municipalities and electoral districts; First Nations, the Provincial and Federal governments have a key role to play in the advocacy and funding of programs and services to improve the health and well-being of North Shore communities. By working together to address substance abuse, governments, service providers and communities can ensure a balanced and coordinated approach to this issue.
# List of Task Force Members

<table>
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1. Executive Summary

Improving health and safety

Substance abuse\(^1\) affects the health and safety of our North Shore communities. Understanding that substance abuse is similar to many other chronic illnesses and is the consequence of various health and environmental factors can help us determine how best to manage substance abuse on the North Shore.

Addiction is not a crime

We know that substance abuse is a controversial issue that elicits strong feelings and tests our ability to separate the harm that drugs do from the people who use them. Those who are physically or psychologically dependent upon drugs are not “criminals” and the pathways that lead to addiction are complex. Early childhood care and socio-economic factors can have a powerful influence on a person with a genetic or metabolic predisposition to addiction. Family breakdown, physical, emotional or sexual abuse are among many factors that may adversely affect an individuals' ability to resist substance abuse. Chronic diseases such as addiction are neither a lifestyle choice nor a moral lapse. Addiction is a disease, not unlike other chronic diseases like diabetes and high blood pressure. We know that addressing substance abuse must include compassion, respect, and care for those who are its victim.

Addiction is a disease

In October 2000, a North Shore Task Force on Substance Abuse was formed by the North Shore Congress\(^2\) to contribute a North Shore perspective on any Lower Mainland or Provincial action on substance abuse. Significant to the

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\(^1\) For the purpose of this Strategy substance abuse refers to the abuse of alcohol, prescription drugs and illicit drugs.

\(^2\) The North Shore Congress consists of: the City of North Vancouver, the District of North Vancouver, the District of West Vancouver, the Village of Lions Bay, Bowen Island Municipality, North Shore Health Region, North Vancouver School District #44, West Vancouver School District #45, the Squamish Nation, the Tsleil-Waututh Nation, Vancouver Port Corporation, and Capilano College. The North Shore Congress was originally created by the Mayor of the City of North Vancouver to provide a forum to discuss issues common to all member jurisdictions.
North Shore process/strategy is the number of jurisdictions that have come together in a single coordinated response. With politicians from five municipalities, two school districts, two First Nation Bands, and a Health Region this is an unprecedented example of agreement, cooperation, and a concerted willingness to act collectively on a significant issue that is important to the entire community.

The Task Force\(^3\) has been working with many sectors to develop a Draft North Shore Substance Abuse Strategy based on the four pillars of prevention, treatment, enforcement and harm reduction. This strategy benefits from and complements other substance abuse policies throughout the Lower Mainland, while emphasizing the unique needs of North Shore communities.

The purpose of the Draft North Shore Substance Abuse Strategy is to:

1. Provide North Shore communities with a comprehensive action-oriented substance abuse strategy that reflects the North Shore priorities in dealing with substance abuse.
2. Build awareness and understanding of substance abuse issues on the North Shore.
3. Indicate "lead" and partner agencies responsible for the implementation of the actions in the strategy.

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\(^3\) The Task Force consists of Congress organizations (with the exception of the Vancouver Port Corporation and Capilano College) and staff representatives from all organizations including the RCMP, West Vancouver Police, Ministry for Children and Family Development and Ministry of Health Services.
Consistent with a four-pillar approach, the North Shore Task Force on Substance Abuse recommends the following four goals:

**Goal 1:**

**Comprehensive Substance Abuse Strategy**

The overall goal is to develop a comprehensive substance abuse strategy for the North Shore that is action-oriented and based on a continuum of care across the four-pillars of prevention, treatment, enforcement and harm reduction.

**Goal 2:**

**Government Cooperation, Multi-Jurisdictional Commitment**

To work with each level of government and with First Nations to cooperate in implementing the substance abuse strategy; to secure funding for the provision of the necessary services on the North Shore; to ensure linkages to related regional policy. This strategy should be implemented through a multi-jurisdictional agreement that coordinates government funding and action within and between their respective jurisdictions.

**Goal 3:**

**Working with the Community**

To encourage participation and involve communities (individuals and organizations) and First Nations in supporting a continuum of substance abuse strategies. This will be achieved by building awareness related to substance abuse and working with communities and organizations towards providing a continuum of programs and services based on the four-pillar approach of prevention, treatment, enforcement and harm reduction.
Goal 4: Coordinate, Monitor, and Evaluate

To develop an implementation plan that results in ongoing coordination, monitoring and evaluation across the four pillars of prevention, treatment, enforcement, and harm reduction. Evaluation must be objective, outcome-based and include a community participation component. This goal involves a clear articulation of roles and responsibilities for all parties with the objective of better coordination and cost-effectiveness.

A series of 14 action areas under the four pillars of prevention, treatment, enforcement and harm reduction have been developed to support the four goals of the North Shore Substance Abuse Strategy.

Prevention involves education about the risks of substance use and builds awareness about substance abuse and what can be done to avoid addiction. Effective prevention should involve coordinated, evidence-based programs targeted to specific populations and age groups. Effective programs focus on the causes and nature of addiction as well as on prevention.

Prevention actions in the strategy include:

- Providing individual and family support
- Public awareness-raising of substance abuse
- School-based prevention education program
Treatment consists of a *continuum* of interventions and support programs that enable individuals with addictions to make healthier decisions about their lives and be encouraged to move towards abstinence. These include detoxification, outpatient counselling and residential treatment (often referred to as intensive treatment), as well as housing, ongoing medical care, employment services, social programs, and life skills.

Treatment actions in the strategy include:

- Continuum of treatment services and facilities
- Increased medical services
- Prescription drug treatment
- Methadone maintenance

Enforcement strategies are key to any substance abuse action plan. To increase public order and support improvements to drug treatment, more effective enforcement strategies could include a redeployment of officers where needed and increased efforts to target organized crime, drug houses and drug dealers. Improved coordination with health services and other agencies to link drug and alcohol users to available programs throughout the region are also key to effective enforcement. Collaboration across enforcement agencies and across all pillars is required.

Enforcement actions in the strategy include:

- Linkages to treatment
- Drug Treatment Court
- Coordination across enforcement agencies
- Annual Reporting and Annual Plan
Harm Reduction

Harm reduction focuses on decreasing the negative consequences of substance abuse on communities and individuals. It recognizes that abstinence-based approaches are not always effective in dealing with hard-core addiction and street-entrenched open drug scenes and that the promotion and maintenance of health and prevention of disease in the substance user as well as the protection of communities is the primary goal of harm reduction programs to tackle substance abuse. There are many successful harm reduction programs around the world that have significantly reduced both the negative health and societal impacts and the costs of drug addiction.

Harm reduction actions in the strategy include:

- Needle exchange
- Services for mentally ill and dual-diagnosed I would classify these as treatment
- Condom distribution
- Community discussion on policy and legislative change

Interrelationship of the Four Pillars

Each of the four pillars requires the interaction and support of the other three to improve public order and public health. In addition, all four pillars must be linked to other strategies at the municipal level, such as business development strategies, community safety initiatives and other health and housing strategies that support the overall well-being of the community. The four pillars of prevention, treatment, enforcement and harm reduction must rest on a strong foundation of community, economic, and social development activities. Further, government cooperation and working with the community and service providers will be critical to the North Shore's success in dealing with substance abuse.
2. Stories

Story of K

K. was a 15 year old West Vancouver girl and a good student when she started experimenting with drugs. She became a regular user of pot, along with many of her friends. One night her girlfriend suggested she try snorting cocaine with her and her boyfriend. She liked it, and went back for more on several occasions. Her girlfriend's boyfriend seemed to have an endless supply, and before long she was hanging out with a bunch of other youth that used cocaine frequently.

Several months later the boyfriend stopped supplying K. She started going to parties where cocaine was available and began forming friendships with a bunch of new young people, some of whom liked to hang out in downtown Vancouver. Before long K. was a downtown regular, and looking for ways to support her habit. Her life was spiralling out of control. Her parents knew something was wrong, but didn’t want to acknowledge how serious the situation had become. She started spending more time downtown than at home, and her parents became increasingly fearful that something was terribly wrong. By the time they fully realized what was going on, it was too late. She had met an older male downtown who became her lover. He introduced her to heroin. She got hooked. Before long she was turning tricks to support him and her addiction. For the last three years K has spent most of her time away from home and efforts by her parents to get her home and into treatment have so far failed. They don’t know where to turn for help.
Story of Q

Today Q. is 18 years old. Her future is uncertain. At 12 years old, at 5'9" with a little make-up and some dressing up she could get into bars. The pain of her life was numbed by alcohol use. Neglected by her mother, she lived part-time with her father. At 13 years of age she started to use other drugs, which she was easily able to obtain through connections in West Vancouver and from her downtown "friends". At 15 years old, a "John", while turning a trick raped her. The experience of her rape haunts her every day. She no longer turns tricks, but continues to bury her pain through increased use of alcohol and drugs. She has connected with a youth worker and has recently shown a willingness to get help. She needs detox and residential treatment now, not 4 - 6 months from now, which is how long it will take to get her into one of the few facilities in the province. How long she will remain open to getting help is anyone's guess, but the chances are her situation will worsen while she waits.

Story of Jeb

Jeb, a young adult who has been given a dual diagnosis, got so strung out on coke that in a low moment, and with his parents pulling strings, he committed himself to detox centre. He came out with a list of prescriptions for his mental and emotional problems and a reference to group therapy. The medicine helped a little, the three month wait to get into group therapy did not help at all, and by the time he got into the group, his motivation had diminished and he dropped out. The medication enables him to keep a part time job, but he does not make enough money to support himself and depends on his girl friend and parents for assistance.
After a quarrel with his girl friend he started taking heroin. When she told him it was either her or the heroin, he promised to get into another rehab program. But it was three weeks to get a doctor’s appointment, and a four month wait for a therapy group. Now he is taking bootleg methadone which he gets from a pusher and argues that he doesn’t need therapy. He jokes, “They say that computers get less and less expensive, but the one you want is always $5000. They say that there are more drug rehab programs but the one you want always has a four month waiting list.”

**Availability of drugs**

How is it to buy drugs on the North Shore? A municipal employee sat down on a bench outside the municipal hall on his lunch break. At a nearby bench was a young girl, perhaps thirteen. He assumed it was the daughter of an employee waiting to go to lunch. The girl did look a little nervous, but hopped up when a car with three young adults pulled into the parking lot. The young girl talked to one of the young men for about thirty seconds, then reached into her jeans and pulled out some money and exchanged it for an envelope. She split one way, the car went the other way. The entire transaction took less than two minutes.

**Story of Mrs. G**

Mrs. G is in her early 80’s. Her family physician paid a house call one afternoon and asked to see her medicine cabinet. Together they got rid of at least twenty bottles of prescription medicine from four different doctors, three different pharmacies, some with expiry dates as old as 1986. Several combinations of these drugs could have been fatal.
3. Introduction

Young people and substance abuse

On April 26, 2001 over 450 parents and young people turned out to attend a forum in West Vancouver on substance abuse. They did not come to be entertained. Their motives were fear and concern. Fear for the growing prevalence of drug experimentation and use among young people, fear about the relationship between substance abuse and deadly diseases, fear about the links between substance use and crime. They came because they were concerned about the lack of response to these fears – uncertainty about who is responsible for what, the absence of treatment programs, the long waiting lists, the controversies around treatment and harm reduction and law enforcement. They came to find out facts and to share experiences.

What we know and what we need to know

We know that since the 1980’s drugs have become more varied, more easily available, more potent and more deadly. The variety of drugs easily available in any community now not only includes heroin and cocaine; but crack cocaine, ecstasy, methamphetamines, new mixtures or "cocktails", and a long list of dangerous prescription drugs. "Whether we like it or not, drugs are a part of modern life. Their use is more common and insidious than many would like to admit. Aspirin, tranquillizers, caffeine, anti-depressants, alcohol and tobacco help get many people through the day. To deal with the increasing complexity of daily life, we have become a society of substance users. Children grow up in an environment when mood-altering, pain-reducing, sleep-inducing substances are widely marketed and accepted."4

Those who use hard drugs do so for similar reasons: pleasure, to ease pain, to flee from problems. Young people often use drugs as part of the risk-taking and rebellion of youth, simple curiosity, to fit into a peer group, or to deal with life's problems. The elderly often use alcohol as a way of dealing with loneliness and isolation, and may use prescription drugs in ways that can be harmful or even addictive.

Addiction is a disease

We know that substance abuse is a controversial issue that elicits strong feelings and tests our ability to separate the harm that drugs do from the people who use them. Those who are physically or psychologically dependent upon drugs are not "criminals" and the pathways that lead to addiction are complex. Early childhood care and socio-economic factors can have a powerful influence on a person with a genetic or metabolic predisposition to addiction. Family breakdown, physical, emotional or sexual abuse are among many factors that may adversely affect an individuals' ability to resist substance abuse. Chronic diseases such as addiction are neither a lifestyle choice nor a moral lapse. Addiction is a disease, not unlike other chronic diseases like diabetes and high blood pressure.

We know that addressing substance abuse must include compassion, respect, and care for those who are its victim.

Care for the addicted begins with keeping drug users alive. “Honouring the goals of saving lives is critical to this level of care and neither discriminatory judgements regarding substance use nor imposition of abstinence or treatment goals are imposed.”5 But this is just a start. Any serious effort to deal with substance abuse must include the four pillars of prevention, treatment, enforcement and harm reduction. Any serious effort must involve a comprehensive strategy,

5 Kaiser Youth Foundation, Weaving Threads Together, 2001
Health and safety are key goals. Community involvement, leadership and commitment. The costs in dollars and wasted lives has become too great for the community to ignore.

These concerns led to the formation of the North Shore Task Force on Substance Abuse. The Strategy benefits from the work done elsewhere in the Lower Mainland, and seeks ways to address the issues as they affect the North Shore. Improving health and increasing safety are key goals in this document.

### 3.1 North Shore Task Force on Substance Abuse

The North Shore Task Force on Substance Abuse was established in October 2000 by the North Shore Congress to contribute to a North Shore perspective on any Lower Mainland or Provincial action on this issue. The North Shore Congress was created by the Mayor of the City of North Vancouver to provide a forum for North Shore decision-making bodies to discuss issues of common concern. One of the first issues to be discussed by the Congress was substance abuse. It quickly became apparent that this was an issue common to all jurisdictions thus the Task Force on Substance Abuse was formed.

The Terms of Reference for the Task Force were finalized on February 22, 2001 and the following is a brief outline of the overarching goal and objectives of the Task Force:

**Goal**

The goal of the Task Force is to develop a comprehensive substance abuse strategy for the

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6 The North Shore Congress consists of: the City of North Vancouver, the District of North Vancouver, the District of West Vancouver, North Shore Health Region, the Village of Lions Bay, the Bowen Island Municipality, North Vancouver School District #44, West Vancouver School District #45, the Squamish Nation, the Tselil-Waututh Nation, Vancouver Port Corporation, and Capilano College.

7 The Task Force consists of Congress organizations (with the exception of the Vancouver Port Corporation and Capilano College) and staff representatives from all organizations including RCMP, West Vancouver Police and Ministry of Children and Family Development.
Objectives

North Shore that is action-oriented and which contributes to the work of provincial and community agencies with responsibilities in this area on the North Shore.

The objectives of the Task Force are:

- To provide an overview of what issues and needs are involved in the rise of substance abuse on the North Shore.
- To identify gaps in and issues with these services and recommend additional and/or changes to services.
- To discuss other strategies and opportunities.
- To consult with the community and service providers.
- To develop an outcome-oriented strategy to address the issues that focuses on the four pillars of community response: prevention, treatment, harm reduction and enforcement.
- Since October 2000, the Task Force has had regular monthly meetings including consultations with existing service providers and has embarked on the first stages of developing a Draft North Shore Substance Abuse Strategy that benefits from ongoing work and research in other Lower Mainland municipalities while reflecting the unique needs of North Shore communities.
3.2 Making of the Strategy

This strategy has been prepared with input from a variety of sources. The initial draft of the Strategy was based on research and experiences from other communities such as Vancouver, Portland Oregon and European cities that have previously addressed the issue of substance abuse. The Task Force held a series of meetings with local professional service providers who shared their expertise and experiences. During October and November 2001 the Task Force hosted a series of five public meetings throughout the North Shore to solicit input on the Draft Substance Abuse Strategy. The Draft Strategy was also posted on all member organizations web pages for review and comment.

This final strategy includes input received from these public consultations. A number of suggestions were also made at the public meetings for specific actions under the Strategy. These will be considered during the implementation phase.

From the public consultations the Task Force learned there was general support for the Strategy as a whole particularly the focus on substance abuse as a health issue. There was also general support for the fact that local elected officials were taking responsibility for putting this issue on the political agenda. All meetings showed strong support for the philosophy and approach proposed by the Draft Strategy which viewed substance abuse from a non-judgemental, comprehensive and multi-jurisdictional perspective that moves away from shame and blame. There was also overall support for the four pillars approach promoted by the Draft Strategy and strong agreement that the success of the final Strategy will depend on addressing all four pillars and their
interrelationship.
4. Background

Substance Abuse is a North Shore issue

The issues of substance abuse span the globe and yet are as close as our neighbourhood and our families. Understanding the local, regional and national context of substance abuse is critical to the development of an effective and appropriate strategy for the North Shore. We are not exempt or protected from either the causes or effects of substance abuse. The patterns of substance abuse on the North Shore are similar to those in neighbouring municipalities, including Vancouver. The visibility and awareness of these issues may be less, but the problems and challenges are similar.

North Shore statistics

The general use of alcohol, marijuana, cocaine, heroin and prescription drugs on the North Shore is not much different from usage in the Lower Mainland and B.C. as a whole. Among some groups the usage is higher than the average: regular use of marijuana by young people is almost double the percentage of the Lower Mainland (17% /10%)\(^8\). Use of cocaine, heroin, and amphetamines by youth is similar to the B.C. average. Counselling agencies report that usage of substances starts at younger and younger ages. North Shore residents of all ages also have a higher than average consumption of alcohol. The relationships between substance abuse and other social issues (mental health, family stability, housing, poverty) are also found on the North Shore.

North Shore not exempt from problems

The North Shore is not exempt from the problems associated with misuse of substances. Intravenous drug use was associated with 11 deaths of North Shore residents in 1996, 9 in 1997. There were 81 drug-induced deaths between 1995 and 1999 (drug overdose, accidental poisoning, suicide). In the year 2000 Lions Gate Hospital had 321 admissions related to substance abuse. There were a total of 126 motor vehicle accidents in 1999 involving illegal drugs and alcohol attended to by the police and RCMP in the three North Shore

\(^8\) McCreary Adolescent Health Survey, 1999
Unique North Shore challenges

The North Shore also has some unique challenges. We have an ageing population that is vulnerable to particular substance abuse issues: the isolated senior depending on alcohol, use of addictive prescription drugs like Benzodiazepines, and dangerous mixing of prescription medicines. The high income of many North Shore residents makes it easier to hide some forms of substance abuse like intravenous drug use. Youth have spending money and can easily access expensive and dangerous drugs.

Uncoordinated response to substance abuse

In the past, the North Shore has relied on a relatively uncoordinated and scattered approach to substance abuse. Prevention programs are partially implemented in local schools. Seaview and West Coast Alternatives provide excellent counselling services within limited budgets for a steady stream of clients but there are no locally operated residential detoxification or rehabilitation facilities. The North Shore Health Region has endeavoured to strengthen programs in mental health. Law enforcement agencies have focused attention on major suppliers of illicit drugs like grow houses and maintained some contacts with school and community prevention programs. Municipalities have broached the issue of awareness in a number of ways – for example parent meetings in West Vancouver and a substance abuse symposium in North Vancouver - but much more needs to be done.

A strategy to reflect North Shore concerns

The North Shore Task Force on Substance Abuse is the first significant effort to; bring together all the relevant decision making (political) bodies, examine the issues, develop a comprehensive strategy, set priorities, and press for full implementation. The Strategy thus reflects both North Shore concerns and the themes emerging across the Lower Mainland on substance abuse issues.
4.1 North Shore Illicit Substance Crime Statistics

There were 765 cannabis-related offences on the North Shore in 1999, representing 76% of all drug crimes on the North Shore. Crime rate for cannabis on the North Shore is 4.3 per 1,000 population compared to 4.0/1,000 in BC. Crime rate for heroin drug offences on the North Shore 0.8 per 1,000 population compared to 1/1,000 in BC.

In 1999, there were 134 heroin-related offences on the North Shore. In 1999, 640 North Shore youth reported substance abuse issues to North Vancouver youth workers. Drug-related offences have increased steadily since 1997 from 121 that year to 494 in 2000 (an increase of 250%).

However, enforcement agencies recognize that substance abuse is about much more than a criminal justice issue and that there are serious health concerns that need to be addressed.

4.2 North Shore Priorities

Understanding the North Shore substance abuse profile and ongoing work with the North Shore Task Force on Substance Abuse and service providers has led to the establishment of several key priorities. These priorities include:

- understanding the importance of strong leadership on substance abuse issues;
- the need for community awareness-raising on these issues;
- the need for better coordination of substance abuse services;
- the need to provide a continuum of care for addicted persons; and,
- the need to ensure groups at risk (such as youth and seniors) are considered in the development of any substance abuse policy.

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strategy.

The following section outlines these priorities in more detail. It also aims to provide a brief needs assessment including gaps and duplication in services, supply and demand for substance abuse services, as well as the needs of service providers. These priorities reflect the unique nature of substance abuse on the North Shore. They also, however, reflect many issues arising from the region, across the country and on an international scale.

4.2(a) Overall Priorities

Priorities for the North Shore Substance Abuse Strategy include actions:

- That are coordinated across governments and North Shore communities;
- That consider substance abuse issues in the overall context of the four-pillar approach including prevention, treatment, enforcement and harm reduction;
- That are monitored and evaluated through community participation and objective analysis;
- That ensure accountability mechanisms are in place; and,
- That are outcome-based.

4.2(b) Leadership

The North Shore will articulate its leadership priorities including:

- The role of local/municipal government in developing and implementing a substance abuse strategy;
- Determining what can be done across smaller communities and how they can assist in addressing addiction and the illegal drug trade;
- A leadership role by the local Health Authority and all North Shore municipalities, First Nations and school districts; and,
• How community leaders, agencies, school boards, churches and other associations can play a larger role in discussing substance abuse and prioritizing action at the community level.

4.2 (c) Community Awareness and Education

The North Shore will work toward building wider community awareness and capacity concerning:

• The nature and extent of substance abuse on the North Shore;
• The need for linkages between prevention and treatment; and,
• Substance abuse as a social, political and health issue – not just a youth or criminal issue.

4.2 (d) Coordination

The North Shore will work toward addressing the need for better coordination across services including:

• Linkages between prevention and treatment service providers;
• Sharing the distribution of resources and workload among service providers;
• Hospitals and community service providers;
• Communities, service providers and police;
• Coordination of enforcement efforts across the two police forces on the North Shore – the West Vancouver Police and the RCMP detachments in North Vancouver and on Bowen Island;
• Better training for service providers;
• Appropriate staffing of service providers and substance abuse programs; and,
• How to address the differences in service levels and waiting time between private and public services.
4.2 (e) Continuum of Care

The North Shore Substance Abuse Strategy will provide a continuum of services for those who abuse substances including:

- Residential treatment on or near the North Shore for adults and youth (there is currently no residential treatment on the North Shore);
- Flexible hours of services including days, evenings, and weekends (DEW);
- An integrated facility offering detox, short-term residential services and long-term supportive housing;
- Increased family counselling, supports and addiction services that include skill-development, capacity-building, and supports for family systems;
- Addressing the current insufficient sessional physician hours to provide case consultation and client support;
- Providing ongoing follow-up support linked to substance abuse treatment; and,
- Considering drug treatment courts and the corresponding treatment programs.

4.2 (f) Groups at Risk

The North Shore needs to address issues related to various groups at risk, such as youth, seniors and First Nations.

Youth:

- Create consistency and effectiveness in prevention programs in schools and communities;
- Address issues of hidden substance use;
- Improve outreach services for youth;
- Address the current limited level of school district coverage on issues related to youth addiction;
- Target prevention programs to first look at what is being used and why, using perspectives and information from youth;
- Increase the number of counsellors and
Seniors:

- Address issues of hidden substance use;
- Address drug abuse by seniors, including those who do not reside in their own homes;
- Address the lack of services for seniors; and,
- Address prescription drug abuse by seniors.

First Nations:

- Develop a substance abuse strategy that is inclusive of First Nations;
- Understand the substance use and abuse profile in First Nations communities as well as in the general population on the North Shore.

4.3 The Regional, National and International Context

Substance abuse is not limited to the North Shore – rather it is part of the growing regional, national and international globalization of the drug trade. Organized crime plays a significant role in the trafficking and profitability of illicit drugs. While recognizing the difficulty in managing international crime and the global drug trade, cities and regions can play a role in decreasing the harms associated with substance abuse at the local level.
4.4 Emerging Key Themes from Related Reports and Policy Documents in the Lower Mainland

Emerging Themes

Since 1997, there has been broad public discussion throughout the Lower Mainland on substance abuse problems. Some emerging themes from these discussions are:

1. The four-pillar approach to substance abuse, including prevention, treatment, enforcement and harm reduction\(^{10}\);
2. An increase in media and public awareness with regard to substance abuse; and,
3. A call for better coordination, monitoring and evaluation of substance abuse programs and services.

Existing policy papers

The following policy papers\(^{11}\) complement work by the North Shore Task Force and also outline what is emerging as a regional, even national, approach to prevention, treatment, enforcement and harm reduction:

(LMMA inventory of services and Needs Assessment and Identification of Issues, October 2000).

Substance Abuse Symposium. District of North Vancouver and North Shore Health Region. June 26, 1999

A Framework for Action – A Four-Pillar Approach to Drug Problems in Vancouver.

\(^{10}\) The evolution and description of the four-pillar approach follows in Section 5.
\(^{11}\) These policy papers are not an exhaustive list but they do provide a broad outline of the general policy direction related to substance abuse.
City of Richmond, April 2001.

Reducing the Harm Associated with Injection Drug Use in Canada, Federal/Provincial/Territorial Advisory Committees, February 2001

An Alcohol and Drug Action Plan for the Downtown Eastside/Strathcona, Community Directions, March 2001

In addition to these documents, the City of Richmond's Crime and Drug Task Force has developed a one-year, inter-agency action plan to address drugs and crime in Richmond. The key principles emerging from Richmond's crime and substance abuse strategy are that it will:

- Be based on the four pillars of prevention, treatment, enforcement and harm reduction
- Use an inter-agency approach including public, business and non-profit sectors of the community to coordinate and implement the strategy
- Consider and complement other regional and national initiatives
- Reflect the unique needs and concerns of Richmond
- Incorporate both short and long term strategies in recognition of the complexity of drugs and crime
- Include measures to track the success of implemented initiatives.
The Vancouver/Richmond Health Board, through its partnership role in the Vancouver Agreement, has been working on a model for providing programs and services for adults with addictions. This work is part of a larger comprehensive substance misuse strategy for addictions being developed under the Vancouver Agreement, an urban development agreement between the City of Vancouver, the Province of B.C. and the Government of Canada to promote and support sustainable economic, social and community development in Vancouver.

4.4 (a) Newspaper Series – Growing Media and Public Awareness

Ottawa Citizen articles In addition to these policy developments, another emerging theme is the increase in the level of media attention related to issues around substance use and abuse. In the Fall of 2000, the Vancouver Sun printed a series that had been previously printed by the Ottawa Citizen. The series, “How America Dictates the Global War on Drugs”, written by Dan Gardner, outlined the issues surrounding the approach taken by the United States to illegal drug use taken by the United States – what has become commonly known as the “war-on-drugs” approach. The series highlights the shortcomings of that approach and the costs, in terms of the economy and human lives and health care associated with the war on drugs.

Vancouver Sun articles Following on from that series, the Vancouver Sun printed another series in the Fall of 2000 and into early 2001 called “Fix”, which outlined the issues of drug use from the user perspective. This series highlighted the serious health issues and costs related to illegal drug use and increased education and awareness about the

On June 29, 2001, the Vancouver/Richmond Health Board released a paper called Adult Alcohol and Drug Services for Vancouver: A Health Reform Framework that supports and advocates a comprehensive four-pillar approach.
Decriminalization/ legalization

marginalization of drug users, particularly in the Downtown Eastside of Vancouver.

In addition, local and national papers have been covering the ongoing debate over decriminalization and/or legalization of illegal drugs such as marijuana and the cost/benefit analysis of such legislative and policy changes. A recent public opinion poll from December 2000 shows 57% of Vancouver residents support the legalization of marijuana, an increase of about 10% from a few years ago. The Economist magazine published in the United Kingdom points to the failures and costs of the “war-on-drugs” approach and recommends the decriminalization of marijuana.

“War on Drugs” has not worked

Media attention related to substance use reflects a higher level of interest amongst the public to do something – something besides the war on drugs approach, and something that balances public health with public order in an effort to make safer, healthier communities for everyone. The emerging consensus supports substance abuse policy is focused on the comprehensive four-pillar approach of prevention, treatment, enforcement and harm reduction.

4.4 (b) Coordination, Implementation and Evaluation

Integrated approach

A key theme emerging from current substance abuse discussion is how to best coordinate, implement, and evaluate programs and services as they fall into a continuum of care, or four-pillar, approach. To address issues that are multi-jurisdictional and cut across areas of responsibility, an administrative structure is required to effectively implement a balanced and integrated substance abuse strategy for the North Shore.
A multi-jurisdictional agreement, between North Shore municipalities, First Nations, the Province and the Federal Government, similar to the Vancouver Agreement\textsuperscript{13}, would provide an administrative vehicle for implementing the North Shore substance abuse strategy. The partners in this agreement could then coordinate, monitor and evaluate implementation on an ongoing basis minimizing duplication of efforts. In addition to the three levels of government, service providers and the broader community would play a vital role in designing, delivering and evaluating programs and services. Efforts would be made to ensure programs and services would be linked to related regional policy and strategies on substance abuse.

\textsuperscript{13} The Vancouver Agreement is an urban social, economic, and community development agreement based on a partnership of the City of Vancouver, the Province of British Columbia and the Government of Canada to improve the health and safety and general well-being of the citizens of Vancouver.
5. Evolution of the Four-Pillar Approach

The foundation of a comprehensive and integrated four-pillar approach to substance abuse based on prevention, treatment, enforcement and harm reduction is common to many substance abuse policy reports. In addition, the four-pillar approach has been a successful component of many European substance abuse models over the last ten to 20 years. Closer to home, cities such as Portland, Oregon and Vancouver have been looking at the four-pillar approach to deliver much-needed substance abuse services to build safer and healthier communities.

Prevention

Each of the four pillars requires the interaction and support of the other three to improve public order and public health. In addition, all four pillars must be linked to other strategies at the municipal level, such as business development strategies, community safety initiatives and other health and housing strategies that support the overall well-being of the community. The four pillars of prevention, treatment, enforcement and harm reduction must rest on a strong foundation of community, economic, and social development activities.

5.1 Prevention

Prevention involves education about the risks of substance use and builds awareness about substance abuse and what can be done to avoid addiction. Effective prevention should involve coordinated, evidence-based programs targeted to specific populations and age groups. Effective programs focus on the causes and nature of addiction as well as on prevention.

14 Section 5 refers extensively to material in MacPherson, A Framework for Action – A Four-Pillar Approach to Drug Problems in Vancouver. City of Vancouver: April 2001
Prevention strategies consist of three main approaches: primary prevention which attempts to prevent substance abuse altogether or delay substance use; secondary prevention aimed at the early stages of substance abuse before serious problems have developed; and tertiary prevention which focuses on preventing serious harm to individuals who have become addicted to substances.

It is important to remember that prevention programs are not simply a response to substance abuse. They are primarily proactive measures that are implemented well before substance use takes place. There is a recognized and growing body of evidence-based prevention approaches that should inform our efforts to develop comprehensive prevention strategies on the North Shore.

### 5.1 (a) Building Public Awareness and Support

#### Awareness of the risks

Individuals and communities across the North Shore and the region have different levels of awareness and understanding about the risks associated with substance use and the factors that contribute to substance abuse. Part of effective prevention program planning involves raising the overall level of awareness within communities related to substance use.

Gaining a broad understanding of the health issues of addiction and substance use provides individuals and communities the information they need to make better decisions about the risks they may be taking with substance use and how to prevent them.
5.1(b) Programs for Youth and Early Intervention

Better decision-making skills

When prevention programs for youth are targeted directly to the youth context, they can have a significant impact on the decisions youth make about substance abuse. In addition to providing information about the potential risks of substance use, prevention programs should provide opportunities for youth to be involved in the development of prevention programs.

Programs that provide interactive learning, life skills, critical thinking and methods for dealing with peer pressure and other influences can be very effective in helping youth develop decision-making skills related to substance use.

Healthy development

Early intervention and comprehensive education programs can be a critical part of preventing or delaying the onset of substance abuse. Programs can be delivered through schools, families, and community agencies while youth are still connected to these resources. Successful prevention programs foster healthy development and reduce the isolation from peer and social supports.

Providing an optimal environment – one without poverty, abuse, or inter-generational substance abuse - for children to grow up in can decrease the likelihood of developing substance abuse problems later in life15.

5.2 Treatment

Continuum of care

Treatment consists of a continuum of interventions and support programs that enable individuals with addictions to make healthier decisions about their lives and be encouraged to move towards abstinence. These include detoxification, outpatient counselling and residential treatment (often referred to as

15 Millar, John S. HIV, Hepatitis and injection Drug Use – Pay Now or Pay Later. p.4
### Range of treatment options

A range of treatment options including primary, secondary and tertiary care that target different populations is essential. In addition, there must be services before and after treatment programs to improve an individual’s chances of moving away from addiction.

### Individual support

The earlier that action is taken in an individual’s substance abuse the better the chance that the harm to the individual and the community will be minimized or eliminated. Often, many people who become addicted are increasingly marginalized as treatment systems fail to provide the support that is needed.

### 5.2 (a) Continuum of Care

Treatment programs need to be streamlined and coordinated to meet the needs of those seeking treatment and to provide a cost-effective approach to substance abuse. Part of the treatment process involves determining where a person is at when they enter treatment and how best to provide care for them. For example, relapse is often a very real part of the treatment cycle and needs to be addressed within a comprehensive treatment system.

### Substance abuse - a chronic disease

To develop a continuum of care, treatment programs must recognize that substance abuse is chronic and requires a continuum of supports to address that reality. Effective treatment includes a series of supports to ensure a range of options is offered to address the differing needs of the individual, to reduce obstacles and to build pathways to treatment.

### 5.2 (b) Treatment Issues

Part of a continuum of care involves providing the correct information to those accessing treatment services and reducing barriers to treatment. An issue on the North Shore is the risks
Prescription Drugs

Associated with prescription drugs, including methadone and others, used in combination with alcohol or other substances. Both physicians and individuals have an important role to play in ensuring that prescription drugs are prescribed and used effectively and properly to reduce the risks associated with overuse and combining substances. In addition, the number of hours and access to physicians and medical services for treatment follow-up and client support is an important part of the treatment continuum.

5.3 Enforcement

Redeployment of resources

Enforcement strategies are key to any substance abuse action plan. To increase public order and support improvements to drug treatment, more effective enforcement strategies could include a redeployment of officers where needed and increased efforts to target organized crime, drug houses and drug dealers. Improved coordination with health services and other agencies to link drug and alcohol users to available programs throughout the region are also key to effective enforcement. Collaboration across enforcement agencies and across all pillars is required.

Link between enforcement and the other pillars

Enforcement consists of a broad range of activities carried out by regulatory agencies, licensing authorities, police, the courts, and other sectors within the criminal justice system. Linkages between enforcement efforts and the other pillars is key to any substance abuse strategy.

Minimize impact of substance dealing

For enforcement to be effective, individuals and businesses involved in the illegal drug trade or in the abuse of alcohol must be dealt with expeditiously. In addition, the police have a major role in assisting communities to minimize the impacts of substance dealing and abuse by working with community organizations and existing crime prevention groups to address...
community health and safety.
5.3 (a) Enforcement Issues

The police and the criminal justice system are often criticized for not putting all drug dealers and addicts in jail. Quite simply, there is a growing recognition that jail is not the place for the addicted — addiction is a serious health problem that requires treatment. There are opportunities with the criminal justice system to provide options for those suffering from addiction that can include diversions from the criminal justice system to more appropriate services. These can include drug treatment courts which provide the opportunity for those with minor substance-related offences to choose the option of treatment over incarceration. This perspective can also provide multiple opportunities for police to link those who are using and abusing substances to treatment and other support services.

Recent debates have raised issues such as the merits or dangers of decriminalization and legalization of certain substances as well as how we can deal with organized crime on a local and international scale. These issues are part of a much larger debate but provide an important opportunity for local communities to determine what the attitudes of their citizens are towards such initiatives. They also provide an opportunity for local communities to consider what can be done, in cooperation with the police and other enforcement agencies in efforts to combat organized crime and property crime related to illicit substances.

Options for addicts

Recent debates have raised issues such as the merits or dangers of decriminalization and legalization of certain substances as well as how we can deal with organized crime on a local and international scale. These issues are part of a much larger debate but provide an important opportunity for local communities to determine what the attitudes of their citizens are towards such initiatives. They also provide an opportunity for local communities to consider what can be done, in cooperation with the police and other enforcement agencies in efforts to combat organized crime and property crime related to illicit substances.

Decriminalization and legalization

Targeting the traffickers

Enforcement efforts on the North Shore focus on targeting the traffickers of illegal substances rather than the users. User populations who are encountered are routinely advised of services available for treatment and victim assistance workers are utilized when necessary. Family members affected by enforcement action are referred to appropriate agencies for assistance.
5.4 Harm Reduction

Minimize harm to individuals and communities

Harm reduction focuses on decreasing the negative consequences of substance abuse on communities and individuals. It recognizes that abstinence-based approaches are not always effective in dealing with hard-core addiction and street-entrenched open drug scenes and that the protection of communities and individuals is the primary goal of programs to tackle substance abuse. There are many successful harm reduction programs around the world that have significantly reduced both the negative health and societal impacts and the costs of drug addiction.

Harm reduction does not condone the use or abuse of illicit substances. It simply acknowledges that substance use does and will occur – and accepts the need to minimize the resulting harm on individuals and communities.

Harm reduction programs can help individuals stay healthier while reducing the spreads of HIV, hepatitis C and other infectious diseases. Harm reduction is needed for the long-term addicted to decrease the likelihood they will cause harm to themselves and to their communities in the desperation resulting from addiction.

5.4 (a) Understanding Harm Reduction

The goal of harm reduction is to reduce harms associated with substance abuse to the community and to individuals. According to the Federal/Provincial Harm Reduction Working Group, there are five principles of harm reduction:

- Do no harm.
- Respect the basic human dignity of persons who use substances.
- Maximize intervention options.
5.4 (b) **Harm Reduction Options**

Harm reduction measures can include providing needle exchanges, providing services for the mentally ill and dual-diagnosed, and consideration of other harm reduction issues such as safe injection health centres, testing street drugs for quality and purity, and considering decriminalization and legalization of certain substances.

Needle exchanges provide a safer, healthier way to ensure dirty needles are not left on streets and in parks, and to ensure clean needles are used to reduce the transmission of HIV, hepatitis C and other blood-borne diseases. In many cities, they are considered as a very effective and important treatment service that reduces harm to individuals and communities.

In addition, the connection between homelessness and mental illness must be addressed in order to ensure appropriate programs and services are provided for those suffering from mental illness and dual diagnosis.
6. North Shore Goals

Consistent with a four-pillar approach, the North Shore Task Force on Substance Abuse recommends the following goals:

Goal 1: Comprehensive Substance Abuse Strategy

The overall goal is to develop a comprehensive substance abuse strategy for the North Shore that is action-oriented and based on a continuum of care across the four-pillars of prevention, treatment, enforcement and harm reduction.

A series of actions under the four pillars of prevention, treatment, enforcement and harm reduction have been developed to support these goals.

Goal 2: Government Cooperation, Multi-Jurisdictional Commitment

To work with each level of government and with First Nations to cooperate in implementing the substance abuse strategy and to secure funding for the provision of services within each government's jurisdiction on the North Shore and linked to related regional policy. This strategy should be implemented through a multi-jurisdictional agreement that coordinates government funding and action within and between their respective jurisdictions.

Goal 3: Working with the Community

To work with and encourage participation of communities (individuals and organizations) and First Nations in providing a continuum of care. This will be achieved by building awareness related to substance abuse and working with communities and organizations towards providing a continuum of programs and services based on the four-pillar approach of prevention, treatment, enforcement and harm reduction.
Goal 4: Coordinate, Monitor, and Evaluate

To develop an implementation plan that results in ongoing coordination, monitoring and evaluation across the four pillars of prevention, treatment, enforcement, and harm reduction. Evaluation must be objective, outcome-based and include a community participation component. This goal involves a clear articulation of roles and responsibilities for all parties and leads to better coordination and cost-effectiveness across service providers.
7. North Shore Actions

The following sections outline the 14 recommended action areas under the four pillars of prevention, treatment, enforcement and harm reduction which support the North Shore goals. More specific actions will be developed as part of the Implementation Plan.

7.1 Prevention

Prevention involves education about the risks of substance use and abuse and what can be done to avoid addiction. Effective prevention involves coordinated, evidence-based programs targeted to specific populations and age groups. Effective programs focus on the causes and nature of addiction as well as on prevention.

7.1 (a) Prevention Actions

1. Individual, Parent and Family Support

   Individual & families Support for individuals and families to prevent substance abuse problems. This would include:

   Counselling Increased and targeted addiction counselling in schools, in communities and by service providers for students, seniors, families, and the general population;

   Community prevention Broader community prevention programs that are targeted to and meet the needs of specific populations including First Nations, women, a variety of youth, seniors and parents.

   Parents support Parent support - Support for parents that focus on awareness-raising and decision-making skills for those living with addicted youth (examples could include workshops for parents, public information meetings, etc)
Youth Workers

Youth worker support – Support for youth workers that focus on awareness-raising and decision-making skills for those working with addicted youth (examples could include in-service training, etc).

Method of delivery

The method of delivery could be through school districts, through senior centres and community centres, through outreach programs, through workplaces (i.e. – in partnership with unions and employers), through tax notices, doctors’ offices, and internet-based programs for example.

Lead Agencies: Local Health Authority
Partner Agencies: Drug and alcohol agencies

2. Public Awareness-Raising of Substance Abuse

Ongoing public awareness-raising and involvement of the community related to substance use and substance abuse which would include: providing information and education for parents, individuals, families, seniors, and youth about the myths, realities, root causes, and health determinants of substance abuse so they develop the skills they need to prevent and deal with substance abuse.

Lead Agencies: Municipalities, Local Health Authority, First Nations
Partner Agencies: Drug and alcohol agencies, school districts

3. School-Based Prevention Education Program

Comprehensive and effective province-wide curriculum-based prevention for implementation through schools. The materials would be age-appropriate and provide a range of content. School-based prevention education should be delivered comprehensively throughout the school system and targeted at all grade levels.

Lead Agencies: North Vancouver and West Vancouver School Districts, Ministry of Education

Suggested lead and partner agencies.
Partner Agencies: Drug and alcohol agencies
7.2 Treatment

Treatment consists of a continuum of interventions and support programs that enable individuals with addictions to make healthier decisions about their lives and be encouraged to move towards abstinence. Treatment actions include detoxification, outpatient counselling and residential treatment (often referred to as intensive treatment), as well as housing, ongoing medical care, employment services, social programs, and life skills.

Treatment Actions

Continuum of Treatment Services and Facilities

Provide a continuum of treatment services and life supports for youth and adults to re-integrate people with addictions into the community. These services would be linked to each other and include:

Detox

A range of detox services. Examples could include home detox, residential detox, day centre or walk-in detox;

Service Linkages

Linkages that ensure: better screening and assessment; referral to appropriate treatment, case management, job training and placement; and housing;

Counselling

Increased and better targeted counselling for individuals, families and groups; relapse maintenance; and life skills;

Rehabilitation Services

Rehabilitation offered through institutional settings (hospitals, for example) across the North Shore and smaller residential treatment settings across the North Shore (in each municipality); Long-term residential treatment - 8-month-to-2-year length of stay - for youth and adults.

Lead Agencies: Local Health Authority
Partner Agencies: Drug and alcohol agencies, Provincial and Federal government,
Municipalities

**Increased Medical Services**

More sessional physicians and medical services (which could include a Regional Addiction Medical Counsellor) for adequate treatment follow-up and client support, including better linkages to and more counselling and life skills supports.

**Lead Agencies:** Local Health Authority  
**Partner Agencies:** Drug and alcohol agencies, Provincial government

**Prescription Drug Treatment**

Strategies and education for physicians, caregivers, and clients and their families to address prescription drug misuse by seniors and the general population. This could include possible monitoring of physician prescription practices.

**Lead Agencies:** Local Health Authority  
**Partner Agencies:** Professional associations, seniors’ organizations

**Methadone Maintenance**

Increase methadone maintenance and treatment for heroin addiction to reduce disease transmission and reduce harms associated with illicit drug use.\(^\text{17}\)

**Lead Agencies:** Local Health Authority  
**Partner Agencies:** Drug and alcohol agencies, Provincial government, Federal Government (Health Canada)

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\(^{17}\) And other replacement therapies if available for other drugs. Please see glossary for a listing and description.
7.3 Enforcement

Enforcement strategies are key to any substance abuse action plan. To increase public order and support improvements to drug treatment, more effective enforcement strategies could include a redeployment of officers where needed and increased efforts to target organized crime, drug houses and drug dealers. Improved coordination with health services and other agencies to link drug and alcohol users to available programs throughout the region are essential for effective enforcement. Collaboration across enforcement agencies and across all pillars is required.

7.3 (a) Enforcement Actions

Linkages to Treatment

Improve drug treatment services to strengthen the ability of police to link users to treatment. Police, judges and crown counsels may refer users to treatment services and address barriers to treatment. Increase community policing efforts to increase the level of community awareness and involvement between enforcement and treatment.

**Lead Agencies:** Local Health Authority, RCMP, West Vancouver Police

**Partner Agencies:** Drug and alcohol agencies

Drug Treatment Courts

Work with other jurisdictions to ensure North Shore has access to Drug Treatment courts and that these courts are implemented along with treatment and other facilities/services.

**Lead Agencies:** Municipalities

**Partner Agencies:** Attorney General, Solicitor General
Coordination Across Enforcement Agencies

Coordinate efforts between West Vancouver Police and RCMP across the North Shore concerning community policing and prevention efforts. Clarify the role of enforcement agencies in prevention.

**Lead Agencies:** Municipalities, RCMP, West Vancouver Police, Crown prosecutors and Attorney General, First Nations peacemakers  
**Partner Agencies:** Drug and alcohol agencies, school districts, First Nations

Annual Reporting and Annual Plan

West Vancouver Police and RCMP will provide an annual public report on enforcement issues that will include: statistics outlining the substance abuse profile (including highlighting changes) on the North Shore; and an annual plan for how enforcement efforts will be developed to meet the needs of North Shore residents as part of the overall substance abuse strategy each year (including progress updates on providing linkages to treatment services).

**Lead Agencies:** RCMP, West Vancouver Police  
**Partner Agencies:** Drug and alcohol agencies, Municipalities

7.4 Harm Reduction

Harm reduction focuses on decreasing the negative consequences of substance abuse on communities and individuals. It recognizes that abstinence-based approaches are not always effective in dealing with hard-core addiction or street-entrenched open drug scenes and that the protection of communities and individuals is the primary goal of harm reduction programs. There are many successful harm reduction programs worldwide that have significantly reduced the negative health and societal
impacts as well as the costs of drug addiction.

7.4 (a) Harm Reduction Actions

Needle Exchange

Provide needle exchange services that are distributed through health clinics (three locations in the North Shore Health Region), through First Nations health services, through the paging of outreach workers and through other health facilities (examples could include: pharmacies, shelters, outreach centres and mobile/temporary health clinics). Needle exchange services will also provide the client/addict with appropriate linkages to treatment.

Lead Agencies: Local Health Authority
Partner Agencies: Youth workers, First Nations, municipalities, drug and alcohol agencies

Services for Mentally Ill and Dual-Diagnosed

Improved and accessible mental illness and dual diagnosis services including housing and other services.

Lead Agencies: Local Health Authority
Partner Agencies: Municipalities, mental illness and drug and alcohol agencies

Condom Distribution

Free and comprehensive distribution of condoms to decrease the risk of disease transmission.

Lead Agencies: Local Health Authority, school districts, municipalities and First Nations
Partner Agencies: Drug and alcohol agencies, youth worker agencies, physicians
Community Discussion

Facilitate community discussion related to harm reduction issues such as: overdose prevention strategies, which could include testing and dissemination of information related to quality and potency of available drugs and distribution, and a quick response team; decriminalisation and legalization of illicit drugs; safe injection health centres; heroin maintenance, etc. From these discussions, consider further research into potential harm reduction measures that could be appropriate for the North Shore.

Lead Agencies: Local Health Authority, Municipalities
Partner Agencies: Drug and alcohol agencies
8. Implementation

Developing goals and detailed actions are the important pieces of policy that need to be completed as part of an implementation plan. In addition, several issues require examination prior to inclusion in the implementation plan:

- A model for multi-jurisdictional commitment across the three levels of government and First Nations to implement the actions;
- What role the North Shore Task Force on Substance Abuse will play in the implementation of the strategy; and,
- What monitoring and evaluation structure needs to be in place to complement and correct the implementation process from the outset.

8.1 Implementation Structure

There are five components of the structure of the Implementation Plan:

1. Task Force

The North Shore Task Force will continue to have monthly meetings and hold workshops to facilitate the approval and development of an implementation of a timely and effective North Shore Substance Abuse Strategy. The Task Force will be responsible to work with lead agencies and service providers to develop an outcome-based and action-oriented implementation plan (including a monitoring and evaluation component from the outset). Task Force members will continue to be the main link with their respective organizations to ensure ongoing commitment of the member organizations.

2. Program/Service Advisory Committee

Composed of both lay and professional people
from the community, the Program/Service Advisory Committee will be responsible for providing advice to staff and the Task Force around potential actions, programs and services to achieve the various action areas identified under the four pillars. This Committee will also provide input into funding proposals, support for advocacy strategies of the Task Force and may be directly involved in implementing approved actions. A Terms of Reference will be developed for this Committee which will provide more details on function and membership.

3. North Shore Multi-Jurisdictional Agreement

To address issues that are multi-jurisdictional and cut across areas of responsibility, an administrative structure is required to effectively implement a balanced and integrated substance abuse strategy for the North Shore. A multi-jurisdictional agreement between the North Shore municipalities\(^{18}\), First Nations, the Province and the Federal Government, similar to the Vancouver Agreement\(^{19}\) would provide an administrative vehicle for implementing the North Shore Substance Abuse Strategy.

4. Staff Committee

Staff from the Task Force member organizations will continue to provide support to the Task Force during the implementation phase. Such support will include:

- Providing a professional staff link between the Task Force and their respective organizations to maintain communications and organizational commitment
- Providing professional expertise to the

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\(^{18}\) All North Shore municipalities

\(^{19}\) The Vancouver Agreement is an urban social, economic and community development agreement based on a partnership of the City of Vancouver, the Province of British Columbia and the Government of Canada to improve the health and safety and general well-being of the citizens of Vancouver.
Task Force

- Assist with the work of the Coordinator
- Assist with the work of the program/service advisory committee
- Carry out tasks assigned by the Task Force

5. Implementation Coordinator

Given the complexity of implementing a multi-faceted strategy involving a number of jurisdictions over an extended period of time, it is necessary to have a person whose job it is to coordinate the overall process.

8.2 Monitoring and Evaluation

The partners in a multi-jurisdictional agreement would coordinate, monitor and evaluate implementation on an ongoing basis without the risk of duplication of efforts. In addition to the three levels of government, service providers and the broader community would play a vital role in designing, delivering and evaluating programs and services.
Substance Abuse is affecting the health and well-being of communities and individuals throughout the Lower Mainland. The North Shore communities have come together to develop a response to substance abuse that complements and benefits from other work being done throughout greater Vancouver, the province and the country.

Government cooperation and working with the community and service providers will be critical to the North Shore's success in dealing with substance abuse.
10. Glossary

Addiction (Synonymous with term dependence)  
Particular behavioural, cognitive and physiological effects that may arise through repeated substance use. Psychological characteristics of dependence include a strong desire to take the drug (cravings), impaired control over its use, persistent use despite harmful consequences, and the prioritization of drug use over other activities and obligations. Physical dependence includes increased tolerance and a physical withdrawal reaction that occurs when drug use is discontinued.

Advocacy  
Informing and supporting people so they can make the best decisions possible for themselves or an act or acts undertaken on behalf of others when they are unable to act on their own.

Alcohol and drug-free housing  
A form of specialized housing provided to people who wish/require accommodation support in an alcohol and drug-free environment.

Continuum of care or support  
A continuum of care refers to the major elements of any kind of overall system of support. Using a population health approach, the term support implies that a person is still responsible for their own health, however may require support and assistance.

A ‘continuum of support for substance misuse ranges from prevention, through early intervention, and on to the traditional concept of intensive treatments for those who have severe dependency problems. The concept of drug dependence as a learned behaviour for many people, implies that the behaviour can also be ‘unlearned’, and this can occur at any point in the learning process. Therefore it is no longer appropriate to conceive of drug intervention strategies as dividing neatly between

20 These glossary terms are from ongoing work related to substance abuse as developed by the Vancouver Agreement throughout 2000-2001.
'prevention' strategies and 'treatment' strategies. It follows from this that any definition of 'treatment' will be an arbitrary one, certainly encompassing interventions which are appropriate in cases of high levels of drug dependence but embracing interventions appropriate to lower levels of dependence to varying degrees.

Similarly, while funding formulae often create the impression of a clear distinction between treatment and prevention, this distinction is arbitrary and makes sense only for conceptual and administrative purposes.

Counselling programs

Counselling (individual, group, family/relationship) is an effective element of treatment. Counselling should be incorporated into many treatment services, from prevention and brief intervention through to relapse prevention and aftercare services.

Day treatment programs

Day treatment programs are community-based services which are more structured and time specific than outpatient services. These services do not have a 'live-in' component and are suitable to individuals with stable and supportive living situations (which may include supportive housing – described below). A client may receive several hours of intensive therapeutic services a day or weeks that may include evening and/or weekend sessions or programs. These services are time specific (i.e. 4 week programs, 6 week programs, etc.) and like other treatment options are supported by pre-treatment and follow-up services by outpatient counselors.

Demand reduction strategies

Strategies that seek to reduce the desire for and preparedness to obtain and use drugs. These programs and policies are designed to prevent the uptake of harmful drug use and include abstinence-oriented strategies aimed at reducing drug use. Their purpose is to prevent harmful drug use and to prevent drug-related harm.
Demand reduction includes treatment, prevention and education.

Services designed to assist a drug dependent person withdrawal from drugs. The range of withdrawal services include medical detox, short-term and residential services, ambulatory services, and home withdrawal management. Residential facilities are the most traditional form of providing withdrawal management. This is for people who require 24hr care and support and stays are an average of approximately one week, during which time clients are offered counselling in addition to medical treatment. Ambulatory (outpatient withdrawal services, support and counselling) are designed for people who wish to go through withdrawal while living on their own, yet need access to services for assistance. Home withdrawal management is an important option for men, women, youth and seniors, and provide an option for those who, in the initial stages feel too unwell to attend ambulatory services, yet require assistance for 24-48hrs. Once home withdrawal is complete, a person can then access ambulatory withdrawal services.

A way of managing drug users involved in the criminal justice system. Diversion programs target people whose drug-using behaviour results in contact with the criminal justice system. Programs vary widely and may occur prior to arrest, after arrest but prior to charging, prior to sentencing, following conviction, and after prison release. A defining feature of drug diversion programs is that offenders may choose whether to undertake drug treatment or participate in the traditional criminal justice process.

A specialized court designed for drug dependent persons who have been charged with drug-related offences. Offenders can be given the option to address their substance dependency through treatment as an alternative to sentencing. In the U.S.A., there are a number of
distinct models currently in operation. However, common characteristics include: defendants are diverted by the courts to drug treatment shortly after arrest; judges are closely involved in monitoring the defendants’ progress; judges, prosecutors, defence lawyers, treatment providers and prohibition staff run the court as a team; and relapses are accepted as part of the treatment process and not considered an indication of failure.

**Dual diagnosed**

Refers to the diagnoses of two conditions synonymously. Term is typically used to describe a person who has a substance dependency and mental illness.

**Epidemic of drug use**

A disease or health issue prevalent in high numbers among the community at a given point in time. Epidemics may be described as ‘widespread outbreaks’ or ‘sudden surges’.

**Evidence-based interventions**

Refers to interventions proven to be successful based on a measure of effectiveness (outcome measures, results of interventions over short and long term). Where empirical data is not available, ‘evidence-based’ may refer to the best possible evidence of success available, which may involve an element of professional consensus and expert opinion. Clinical treatment protocols for substance dependency and other health related issues are increasingly used to guide and standardize interventions. Although variations in individual treatment is often necessary, materials such as clinical treatment protocols set standards based on the best available evidence at the time.

**Harm reduction approach**

Policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual and encompasses a wide range of approaches, including abstinence-oriented strategies. This approach focuses on both licit and illicit drugs. It includes preventing anticipated harm and reducing actual harm to individuals and the community.
The term harm reduction should always be used with the context in which it would be operational, for example, what are the specifics of harm reduction. Harm reduction includes public health and safety initiatives such as approaches that decrease criminality, overdose etc. Harm reduction approaches can be directed to different groups (individual, families, different communities) using different types of treatment and interventions. The Canadian Centre on Substance Abuse National Working Group on Policy (1997) defined harm reduction as “a policy or program directed towards decreasing the adverse health, social, and economic consequences of drug use without requiring abstinence from drug use”.

<table>
<thead>
<tr>
<th>Health Outcomes</th>
<th>A change in the health of an individual, group of people, or population, which is attributable to an intervention or series of interventions.</th>
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<tbody>
<tr>
<td>Health Promotion</td>
<td>Health promotion is an approach (rather than a specific set of services) that focuses on the broad determinants of health, the underlying causes of illness, and factors that affect the ability to cope. Rather than dealing primarily with people at high risk, health promotion looks at the health of an entire population. Health promotion includes education and support, to help populations reduce any health risks associated with life-style; and take responsibility for and become actively involved in decisions that affect their health.</td>
</tr>
<tr>
<td>Heroin trials (Heroin Treatment Centres)</td>
<td>Legalized facilities where health personnel would provide prescribed heroin to users with the aim of stabilizing and reducing their dependency, preventing drug overdose deaths, provide clean injecting equipment, and provide relevant health services.</td>
</tr>
<tr>
<td>IDU</td>
<td>Injection drug user</td>
</tr>
<tr>
<td>Incidence</td>
<td>Number of new cases (usually per year) in a given population at any given point in time.</td>
</tr>
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</table>
### Integration
Organization of service entities along a continuum, ranging from cooperation between agencies to full amalgamation of governance, management and service delivery structures, in order to ensure that the client's needs are met in a coherent, unified, holistic and efficient manner.

### Intervention
An action taken to cause effect or make a diagnosis.

### NARCAN
Narcan, known also as Naloxone, is a short-acting opiate agonist which decreases (or in some cases increases) the effects of opiates in the body. Effects of opiates are not felt if used after the administration of Narcan. The administration of Narcan can potentially be fatal following consumption of large amounts of opiates. As the effects of Narcan wears off, cumulative opiates in the blood can cause overdose.

Naltrexone acts in a similar way but is longer acting that Narcan and is useful for those in treatment. Antibuse is a similar acting drug for those who are alcohol dependent. Consumption of alcohol while taking Antibuse causes a number of side effects making a person feel unwell. There are agencies currently researching similar medications to be used with persons dependent on cocaine.

### Needle exchange programs
Providing sterile needles to drug users is an inexpensive and successful way of reducing the transmission of HIV/AIDS and Hepatitis C. Anyone wanting clean needles must register first, and present one used needle for one clean one. To maximize the effectiveness of this program, needles must be available to ALL users, through easy and judgement free access immediately approximate to their intended use. Needle exchanges link clients in with other health and social services.

### Opiate replacement therapy
Opiate replacement therapy (sometimes termed 'substitute pharmacotherapies') refer to a range
of synthetic opioid medications used to stabilize opiate dependent persons. Methadone maintenance is the most common treatment of this kind. Effective opiate replacement therapy is undertaken in conjunction with a wide range of other support services, such as access to counselling and primary care treatment. Other medications currently in trial or use in other countries for the treatment of substance dependency include LAAM (Levo-Alpha-Acetyl-Methadon); Buprenorphine; and Naltrexone.

**Outputs**
Measurable direct results of activities, such as products or services provided (example: number of immunizations given).

**Outreach**
Services are taken to the consumer (e.g., at home, at work, in a facility) rather than requiring the consumer to attend the service, clinic or hospital.

**Population Health**
Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development and health services.

As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations.

**Prevalence**
The number of existing cases at any point in time in a given population.

**Primary Care**
The first point of contact with health care professionals providing preventive, diagnostic and therapeutic care. It is at this entry level that most health conditions are managed, and where services are mobilized and coordinated to
<table>
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<tr>
<th><strong>Primary Prevention</strong></th>
<th>Respond to people's needs. Primary care may include referral to more specialized levels of care, e.g., secondary (hospital or specialist care).</th>
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<tbody>
<tr>
<td><strong>Public Participation</strong></td>
<td>Refers to initiatives and interventions aimed at preventing a problem entirely.</td>
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<tr>
<td><strong>Quality assurance</strong></td>
<td>Achieving health goals requires public participation, informed choices and decision making, and shared responsibility among individuals, private sector and non-government organizations, communities and governments.</td>
</tr>
<tr>
<td><strong>Residential Long Term Treatment</strong></td>
<td>An ongoing program to ensure standards of service delivery are met.</td>
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<tr>
<td><strong>Rehabilitation</strong></td>
<td>Many people require refuge in supportive accommodation with medical care and counselling while they resolve long-standing problems and establish new patterns of behaviour. Long-term treatment provides the opportunity for people to move forward in their treatment plan or transition back into independent living. Clients may live in a recovery home until they are stable enough to attend residential treatment, some may live in these homes while attending day treatment and others may need this service to regain their stability after treatment to prepare for ongoing recovery and independent living. The typical stay is around 90 days.</td>
</tr>
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<td></td>
<td>The nature of this service involves close, communal living among people in the very early stages of recovery or treatment and are typically very vulnerable to relapse. For this reason these services are often 'client specific' (e.g. gender specific, 12-step programs, methadone clients, dually diagnosed, etc). For many clients the adequacy and appropriateness of the residential treatment is instrumental in the success of the treatment outcome goal.</td>
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<tr>
<td></td>
<td>In a broad sense, rehabilitation incorporates health promotion and injury, disease and disability prevention. In a global sense,</td>
</tr>
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</table>
rehabilitation incorporates advocacy and collaboration with other agencies to address more general societal issues.

Rehabilitation services may provide access to physical, mental, social, vocational, preventive, recreational, and psychosocial measures and initiatives. Rehabilitation strategies may fall under the domains of personal life, leisure, education and work. Examples of rehabilitation may include case management; residential treatment and support; crisis services; social services; housing; vocational rehabilitation; treatment; stabilization; peer support; family support; and personal skill development.

Regionalization

The creation of regional or local governance structures to direct and integrate the operations of health services.

Residential Treatment programs

Residential facilities are the most traditional form of withdrawal management. This is for people who require 24hr care and support and stays are an average of approximately one week, during which time clients are offered counselling in addition to medical treatment. These facilities deliver more intensive support than recovery homes.

Safe injection health centres

A legally sanctioned, physically and emotionally safe and secure environment where IDU can learn about and engage in safe injection. Ideally they provide access to clean injection equipment (needles, syringes, spoons etc.), sterile water, bleach kits and education regarding techniques of safe injection as well as safe sex and their importance. Trained medical staff of staff trained in first aid are on hand to intervene in cases of drug overdose.

Safe injection health centres provide an environment for the establishment of trusting relationships with peers, recovering and recovered IDU, and health care professionals. These connections may engender an
<table>
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<tr>
<th>Key Concept</th>
<th>Description</th>
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<tbody>
<tr>
<td>Secondary prevention</td>
<td>Brief or early intervention to stop the progression of health problems.</td>
</tr>
<tr>
<td>Secondary care</td>
<td>A referral to a specialist is an example of secondary care.</td>
</tr>
<tr>
<td>Sobering centre</td>
<td>A safe and secure location for intoxicated persons to 'sleep off' the effects of substances. A sobering centre would have withdrawal management services and primary care facilities. The centre would be open twenty four hours and provide short-term assistance.</td>
</tr>
<tr>
<td>Standard</td>
<td>An expected level of performance against which actual performance can be monitored.</td>
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<tr>
<td>Supply reduction</td>
<td>Supply-reduction strategies are designed to disrupt the production and supply of illicit drugs. They may also be used to impose limits on access to and the availability of licit drugs – an example is legislation regulating the sale of alcohol and tobacco to people under the age of 19 years. Supply reduction strategies may target major smuggling organizations and international interdiction. Strategies also include street level supply reduction.</td>
</tr>
<tr>
<td>Supportive housing</td>
<td>A variety of living arrangements (usually self-contained living units) for people with health or social problems who are able to live independently with the assistance of a range of support services and the provision of a housing subsidy.</td>
</tr>
<tr>
<td>Tertiary prevention</td>
<td>Prevent problems from worsening at a community or individual level. Prevention of transmission of communicable disease or drug overdose deaths are examples.</td>
</tr>
<tr>
<td>Tertiary care</td>
<td>Intensive, specialized care provided to those who cannot be managed at the primary or secondary</td>
</tr>
</tbody>
</table>
Treatment on demand

Providing treatment to those who demand it. This requires treatment to be readily available and accessible.

Treatment

Prevention and treatment are often seen as separate strategies, however they might better be seen as two ends of a continuum. Prevention may include face to face education, mass communication promotions, advocacy, legislative strategies and community development. Similarly, treatment can include information giving, screening and early and short-term intervention strategies, which clearly have a preventive function.

A definition of treatment should allow for the biological, psychological and social factors which affect drug dependence, and allow for the active role of the person in treatment. Using this rationale, treatment has previously been defined as "any person-to-person intervention which is designed to identify and minimise hazardous, harmful, or dysfunctional drinking/drug taking behaviour" (Ali, Miller, Cormack, 1992).
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