Youth Substance Use: A Critical Analysis of Tensions Between Federal Policy Discourse and Frontline Service Provision in Ontario

Farihah Ali

A DISSERTATION SUBMITTED TO THE FACULTY OF GRADUATE STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN HEALTH
YORK UNIVERSITY
TORONTO, ONTARIO

MARCH 2021

Abstract

Substance use – ranging from experimentation to problematic use and addiction – is most common among youth and young adults. Evidence shows that the earlier in life individuals begin to use substances, the higher the risk for substance misuse. Adolescence and young adulthood are life stages when behaviours and habits become established. They are also periods of social and developmental change as youth navigate through challenges and transition through social roles. In order to respond to substance use issues in Ontario, the substance use service provider arena is guided by federal policies and offers a range of services from both public and private domains, intended to support youth experiencing substance use issues.

My dissertation had three objectives: 1) to assess the experience of frontline service providers to shed light on their perspectives on challenges faced by youth who use substances; 2) to critically evaluate representations of substance use among youth in a federal substance use strategy document that informs provincial level practice; and 3) to assess the policy implications of the tensions between dominant representations of substance use in policy documents and the lived experience of frontline service workers in the field of substance use for policy, practice and equity. To achieve these objectives, I conducted an online survey of Ontario service providers recruited from youth-oriented addiction substance use treatment organizations, I followed up with qualitative key informant interviews of a sub-sample of willing survey participants, and I assessed dominant representations of the problem of substance use using the critical policy approach of WPR (Bacchi, 1999), through an examination of the National Canadian Drugs and Substance Use Strategy (CDSS).

My findings revealed significant tensions between theory and practice. While frontline providers expressed the need for harm-reduction, non-pharmacological and prevention initiatives for youth, the National Strategy downplayed this need, as well as the significance of the social determinants of health, while largely framing the behaviours of users of substance as falling under the jurisdiction of the criminal justice system. I offer policy recommendations on how to reduce the identified gaps between dominant representations and practice and propose strategies to encourage policy makers to develop youth-appropriate substance use reduction policies.

Acknowledgements

Completing this degree has been a long journey. I have been extremely blessed to be surrounded by immensely encouraging and inspiring people, during what seemed to be the most challenging years of my life. I am thankful for everyone who has listened to me vent, been a shoulder to lean on, distracted me when I needed it the most, and stood by me through every obstacle and achievement.

Thank you to the frontline service providers who have shared with me their experiences and thoughts. Without their willingness to participate, this dissertation would not have been possible.

My sincerest thanks are extended to the following members of my Doctoral Committee: Dr. Claudia Chaufan, Dr. Tara Elton-Marshall and Dr. Marina Morrow for their knowledge and guidance in reaching this milestone. I am forever grateful to Tara for her ongoing mentorship, insight and support. Similarly, I would like to thank Marina for her invaluable feedback, expertise and time. To Claudia, my supervisor, I convey a special note of appreciation for her dedication, commitment, and encouragement throughout this challenging journey.

I am grateful for all my friends- Audrey, Elma, Fawzia, Shawna, Shazmin- who have provided unconditional moral support, and have listened to me ramble about my PhD work, even when it didn't make sense. Thank you especially to my friend and colleague Cayley, who has allowed me to vent whenever the need arose, and provided me with guidance and dependable support.

To my niece, Sofia and nephew, Niko, thank you for the inspiration and motivation to complete this degree, and providing me with a playful escape that I desperately needed.

I thank my siblings, Desiree, Nadir and Samira for their encouragement, patience and faith in me and being constant sources of assurance.

A special acknowledgement to my devoted partner Sina, who has instilled confidence in me when I was filled with self-doubt. Thank you for supporting me through the highs and lows of this endeavor.

Last but certainly not least, none of this would have been possible without the unwavering emotional, material and moral support of my loving parents, Shamimeh and Shahrok. I am forever grateful for their profound sacrifices in this journey. To my mother in particular, this achievement is a testament to her unconditional love that strengthened my inspiration to complete this program successfully. This degree is as much hers as it is mine.

I dedicate this research to all youth who struggle with substance use.

Table of Contents

Chapter 1: Introduction

Canada is currently experiencing a major public health crisis of increasing substance-related issues and mortality rates, which is exacerbated by the unprecedented crisis posed by the COVID-19 pandemic. While the public health crisis of substance use may be silent, it is severely impacting the health and lives of Canadians, communities and families across the country. Leading among these substances are opioids: in Canada between January 2016 and March 2020, there were 16,364 opioid-related deaths and 20,523 opioid-related poisoning hospitalizations, and the numbers continue to rise (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020).

Furthermore, the current global pandemic has affected the illicit drug supply where a recent report found that substance users have experienced a reduction in their drug supply, coupled by increased cost and tainted quality, potentially worsening related health consequences, including the risk of overdose and poisonings (CCSA, 2020). Some jurisdictions across Canada have also experienced a significant increase in opioid-related overdose deaths during the pandemic (Toronto Public Health, 2020). A British Columbia Coroners Service report found a 93% increase in the suspected illicit drug toxicity deaths in May 2020 compared to May 2019 (British Columbia Coroners Service, 2020). Similar trends have been seen in Toronto and Calgary (City of Toronto, 2020a). In 2020, between January and March, 1,018 opioid-related deaths occurred, of which 96% were accidental, and more than 4,560 suspected opioid-related overdoses occurred between the same timeframe in Canada (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020). In Ontario, the average weekly overdose death rate increased by 38% in the first 15 weeks of the pandemic, compared to the 15 weeks before (Ontario Drug Policy Research

Network, 2020). However, the crisis in Canada is not restricted to opioids, as 82% of apparent opioid-related deaths from January 2016-June 2017 involved one or more of a non-opioid (Belzak and Halverson 2018). Prevalence of polysubstance use is also seen in data from January to June 2020, whereby 52% of accidental opioid deaths also involved use of a stimulant (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020).

While most Canadians will use some kind of psychoactive substance such as alcohol and illicit drugs in their lifetime (Government of Canada, 2018a), and may use them for reasons that are not necessarily harmful, including experimentation, enjoyment, socialization or to cope with stresses or pain, for some, the use of substances can and will become problematic, as it can lead to addiction (Sinha, 2008)[1]. Approximately one fifth (21.6%; n=6 million) of the Canadian population will face addiction in their lifetime (Pearson et al., 2013).

The landscape of substance use is continuously evolving, as new substances emerge and gain popularity. The types of substances people use depend on age, family, social, economic, and political factors, which recognizes the importance of the social determinants of health (SDOH) (Abuse, 2016a). In addition, substance use policies may also impact the use, perception and accessibility of substances and services. It follows that it is important to assess the policies that shape the operating space of service providers as they respond to the changing landscape of substance use among their clients and the frameworks that inform service design and delivery.

[1] In recognition that the term 'addiction' is fraught with moral implications, I elaborate on the use of this term and my position on pg.16. More specifically I use 'substance misuse' because it is consistent with the bulk of the research literature, as well as the DSM-5. However, I still recognize that it is a problematic term, especially within the context of harm reduction frameworks.

While individuals from all age groups engage in substance use and can experience addiction, certain populations, such as Indigenous Peoples, low income groups, and youth, may experience substance use issues at disproportionately higher rates and are particularly vulnerable to the negative health and social consequences (Spooner, 2005). Political and social contexts beyond individual control impact how people use substances and this context may be missed by policy makers who design interventions. And yet, as my work attempts to show, the missing contexts explains why many marginalized groups- marginalized by virtue of income, education, and race/ ethnicity among other social determinants- experience worse health outcomes, and why it is imperative to identify what role the social determinants of health play in substance use and in advancing policy-making (Spooner, 2005).

For the purpose of my dissertation, I have examined youth users because it is during adolescence that most substance use is initiated, and can often lead to long-term use (Roberts et al., 2008) - even when trajectories may begin in mere experimentation, they can and often do lead to problematic use (Schulte and Hser, 2013). Adolescence and young adulthood are key life stages when behaviours and habits become established and is a period of social and developmental change as youth try to navigate through challenges and transition of social roles. Evidence shows that the earlier in life that one starts using, and greater the frequency of their use, the higher the risk for addictions (Schulte and Hser, 2013). Recent Canadian surveys have shown that tobacco, alcohol and cannabis are among the top substances used by youth (Government of Canada, 2019a). In order to respond to these issues, substance use services offer a wide range of services from both public and private domains intended to support individuals with their substance use issues, from prevention initiatives to treatment options (Abuse, 2016b). Services play a pivotal

role in working with users to help them cope and manage their substance use issues, and different services are available depending on where clients are at with their use and what kind of support they are seeking. These programs also depend upon the individual's specific needs and life circumstances and can be influenced by substance use paradigms and policies.

Historically and even to this day, substance use issues have been framed by paradigms of 'wrongness', transitioning from moral frameworks of substance use towards a criminalization framework and most recently, a public health framework. While the latter may not engage in moral evaluation, it often "blames the victim" by depoliticizing the context of substance use and ignoring its social determinants. As such, while I started out my investigation intending to assess the lived experience of frontline service providers to understand the challenges of seeking service provision, the patterns of substance use, and responses by service providers to understand substance use issues among youth, in the course of this assessment, and as is frequently the case with qualitative research, I realized that a critique of the frameworks and concepts of the policies within which they worked was necessary. Indeed, I found a gap between what I heard from frontline providers and the very framing of substance use problems in the literature that provides the foundation for service provision. I concluded that if service provision is influenced by policy formation, then I had to critically examine the official discourse around substance use at the national level which informs provincial guidelines – Ontario in the case of this study. Such an assessment would allow for a more comprehensive understanding of the shifts and tensions with public responses to substance use, and the appropriateness of such responses.

Therefore, I have taken a multipronged approach, engaging the unique perspectives of frontline youth service providers, as well as examining documents that track the evolution of policies which guide substance use service provision at the federal and provincial levels, to assess the implications of these policies against actual practices. I surveyed and interviewed a sub-sample of frontline service providers' in Ontario who have the contextual background and understanding of youth substance use characteristics and provision within their organization. Since substance use patterns among youth are constantly changing, services must reflect these changes and provide effective and relevant responses, which will also speak to how dominant paradigms frame the problem of substance use among youth.

In terms of the reflection of policies on services, I have critically examined a national substance use strategy, the national 2017 Canadian Drugs and Substances Strategy (CDSS) which aims to guide substance use service provision and regulation nationally. This document ostensibly acknowledges the internationally recognized four-pillar approach of prevention, harm reduction, treatment and enforcement, an approach that addresses the potential harms of, and is deemed an effective way of addressing, substance use issues (Government of Canada, 2017). While there are many strategies and documents that speak to substance use in Canada, the CDSS was selected due to its national stature and the ways in which it helps shape, inform, and frame substance use policies, directly at the federal level, and indirectly at the provincial level. Federal documents like the CDSS are responsible for laws and regulations controlling substances in Canada and inform how service delivery is implemented at the provincial and territorial levels. In my analysis, I question how this strategy has represented the problem of substance use, by using Bacchi's (1999) policy analysis tool entitled 'What's the problem represented to be'

(WPR) (Bacchi, 2009). This approach allows health researchers to reveal how problems are conceptualized by critically assessing what policies are implemented to address them. In my case, I reveal that despite the benign rhetoric calling for society to see youth substance users as individuals who need support, material and emotional, in practice the policies largely criminalize these individuals as they engage far more the criminal justice system than social services and health systems, and largely fail to include conversations about youth users in their policies.

While the shifts in substance use policy have been documented by other scholars, to the best of my knowledge, my unique contribution is to couple a critique of national policy with an assessment of the lived experience of frontline youth service providers and compare one against the other. I believe that this approach can shed light on the tensions between policy and practice and provide invaluable information regarding the appropriateness of youth service provision and the impact of national policy on substance use service provision at the provincial level, as identified by frontline service providers.

Statement of the Problem

In order for services to effectively respond to substance use changes, it is important to examine the substance use landscape among youth and youth service provision across Ontario, from the perspective of frontline workers. Since policy changes are often driven by research and can have direct effects on service provision, I was interested in identifying patterns of substance use among youth, which types of services are offered- and which are deemed effective and what prevailing gaps are present in youth service provision. I sought to identify this information to provide policymakers a provincial perspective from the frontline, one that is largely missing, and

likely the most valuable contribution of my dissertation. I decided to survey and interview service providers over youth themselves because I was specifically interested in the lived experience of the former, given that engaging with them offers the opportunity to understand how policy is actually implemented and how certain approaches and philosophies vis-à-vis such issues are conceptualized on the frontlines and impact service provision.

Based on the relationships frontline workers develop with their youth clients, they have a comprehensive understanding of what the population needs, what the gaps in treatment and provision of care are, the challenges that surround treatment and support, and they are thus in a good position to identify gaps that are largely missing from discourse. Engaging them ensures that recommendations about research priorities are relevant, appropriate and effective to those that are impacted by such decisions (Greer et al., 2016). As such, we need to value and incorporate the experiences and knowledge of service providers who work on the frontlines. If we believe that service providers are well positioned to identify the gaps and challenges and implement appropriate approaches to address substance-related issues, then it is imperative that we connect with them and meaningfully engage in conversations about their experiences. My findings can inform future research on the impact of these policies on youth. The experience of youth themselves, however, is beyond the scope of my dissertation.

Substance Use and Substance Use Disorder: Concepts and Their Historical Evolution

When discussing issues related to substance use, words can be powerful, especially when used to inform, educate, clarify, support, and encourage both the public and users. However, words also have the potential to misinform, shame, discourage and isolate concepts of substance use

(Broyles et al., 2014). Therefore, and before laying out the questions guiding my research, a clarification of the concepts used throughout my dissertation, such as addiction, problematic use, disorder, misuse and so on, is in order. Health professionals, service providers and community leaders who engage with preventing, treating and supporting recovery for substance use issues employ a variety of competing terms to describe substance use. However, this lack of common language - which is often medicalized- fosters fragmentation and has the potential to cause confusion in public discourse and perpetuate stigma (National Alliance of Advocates for Buprenorphine Treatment, 2004). While the impact of language will be further explained in the findings section, it is important to note that in an attempt to avoid medicalization and stigmatization, the meaning of concepts in the field has historically evolved.

A *substance* is anything that can alter a person's mood or cognition. Substances can range from caffeine and alcohol to cocaine and heroin (Gould, 2010). For the purpose of my dissertation, a 'substance' will be defined as any psychoactive compound that has the potential to cause social and health problems, and could potentially lead to addiction (McLellan, 2017). These substances may be categorized as legal (e.g. alcohol) or illegal (e.g. cocaine); or controlled substances for use by licenced prescribers for medicinal purposes (e.g. opiates) (McLellan, 2017). The terms 'drug' and 'substance' often get used interchangeably as both terms characterize the use of something that has altered a person's mood or cognizance. The term 'substance' is also used more frequently than 'drugs' to better reflect the full range of psychoactive substances (Toronto Drug Strategy, 2005). Additionally, the term 'substance' is consistent with the current Diagnostic and Statistical Manual of Mental Disorders (DSM-V; 2013) terminology (Kelly et al., 2016). As such, for my dissertation, I will use the term 'substance', as opposed to drug.

Substance use broadly refers to any use of a substance (Marshall and Spencer, 2019). It encompasses legal, illegal, medicinal, and recreational use. Substance use occurs on a continuum; from beneficial use, to non-problematic use, to problematic use and chronic dependency (Marsall and Spencer, 2019). Substance use can begin at one point along the spectrum- starting at no use-> experimental/social use-> substance misuse-> substance use disorder -> recovery- which I will discuss in greater detail shortly (Veach and Moro, 2017). Generally, substance use is a progressive process ranging from no use to addiction; although the continuum does not necessarily apply to everyone. For some people, use of one substance may be beneficial or harmless, while use of another substance may be problematic or harmful (Representative for Children and Youth, 2016). While some people develop chronic dependency that may require interventions, many others do not, and many people who use substances suffer few, if any, harms (Representative for Children and Youth, 2016). Substance use becomes problematic when it negatively affects a person's life or the lives of others around them. Understanding the terms that are used to describe unhealthy use varies. According to the American Society of Addiction Medicine, substance misuse describes the spectrum of unhealthy use of a substance that range from low-risk use, at-risk use, and harmful use (Mahmoud et al., 2017). It is fundamental to differentiate between the concepts of use and misuse, as the line often times can be easily blurred and the terms can be incorrectly used interchangeably, perpetuating stigma and misconceptions (Mahmoud et al., 2017).

Substance use problems, often referred to as substance 'abuse', substance 'misuse' or 'problematic' substance use, are often used when substance use causes harm to the individual or the people around them. Substance use problems can ultimately lead to misuse and dependency (McLellan, 2017). As I discovered throughout my investigation, there are many ways to

characterize substance use problems, and virtually impossible to do so without normative connotations, positive or negative, so I made my own choices based on my own values and on pragmatic considerations. Therefore, I used the term 'substance misuse' over 'problematic substance use' and 'substance abuse' because I question the label of 'problematic' as what may be problematic to some may not be to others. What about 'abuse'? In this case I believe that 'abuse', like addiction and problematic - are overtly negative, whereas 'misuse' is less so (Toronto Drug Strategy, 2005). The term 'abuse' perpetuates social stigma and judgment, which can further marginalize people from the supports and services they need (Toronto Drug Strategy, 2005). The Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association also currently defines substance abuse as a "maladaptive pattern of substance use resulting in clinically significant distress and impairment" (Centre for Substance Abuse Treatment, 2012), which medicalizes substance use by employing a biomedical paradigm.

I believe that 'misuse' offers the same intended meaning as what has been traditionally been termed as abuse, but with less stigma and judgmental perspectives that abuse holds, and without the purely biomedical lens (National Alliance of Advocates for Buprenorphine Treatment, 2004). The term misuse also further characterizes a broader range of usage patterns, which many people who use substances may identify with and not consider as 'abusive' or 'problematic' (National Alliance of Advocates for Buprenorphine Treatment, 2004). As such, for the purpose of my dissertation, I will use the term 'substance misuse'.

For similar reasons, when discussing addiction and dependency, I use the term *substance use disorder (SUD)*, because they encompass dependence and addiction to licit and illicit substances

(National Alliance of Advocates for Buprenorphine Treatment, 2004). This term is helpful because it encompasses a wide range of severity levels, ranging from problem use, dependence and addiction (National Alliance of Advocates for Buprenorphine Treatment, 2004). However, while the term 'disorder' can be considered a medicalized term, and thus can be potentially stigmatizing, I believe that it is more appropriate than addiction and dependency. SUD is used to describe problematic substance use that leads to clinical and functional impact on an individual's health, behaviours, and daily activities (Marshall and Spencer, 2019). Addiction on one hand cannot be used as an umbrella term for substance use disorders, because not all substance use disorders reach the level of addiction, and addiction as a term in isolation may be misleading and can be interpreted as an addiction to any addictive disorder, such as gambling, eating or shopping (National Alliance of Advocates for Buprenorphine Treatment, 2004). Similarly, the term dependence cannot be used as an umbrella term for substance use disorders as not all substance use disorders meet the criteria for dependence (National Alliance of Advocates for Buprenorphine Treatment, 2004).

The experiences of substance misuse or SUD evidently varies based on the individual, and there is often a combination of individual and social factors that can contribute to why an individual's substance use may result in substance misuse or SUD, acknowledging the role of the social determinants of health. Substance use disorder is a complex process where problematic patterns of use can negatively interfere with an individual's life (Grella et al., 2001). According to the Centre for Addiction and Mental Health, a simple way to understand and identify substance use disorder is through an approach called the 4C's: Craving, loss of control of amount or frequency of use, compulsion to use and continued substance use despite consequences (Herie et al., 2010).

Together, these signs refer to chronic use of a substance, and could potentially lead to other health or social issues (Herie et al., 2010). However, even within SUD diagnoses, not all people will experience the same symptoms or issues, which is why it is important to understand the nuances between the different terms used, and when and how they have been applied. One way to achieve this is through developing a better historical and conceptual understanding.

Substance misuse is not a new phenomenon- it can be traced as far back as 8000 B.C. Throughout the world, many substances that have been misused originated from medicinal purposes (Boyd et al., 2008). In the late 1800s and early 1900s, alcohol, cocaine and opiates were commonly prescribed by physicians and added to patient's medicines for illness and treatment purposes. The dramatic rise in consumption, specifically among alcohol, in the late 18th and early 19th centuries led to a shift from moral/religious/criminal conceptualizations to medical conceptualizations (Boyd et al., 2018). This 'discovery of addiction' led to the shifting paradigm of characterizing substance-related problems, as conditions that could be clinically fixed (Anderson et al., 2010). As such, substance use and misuse are largely rooted in the world of medicine. The medicalization of deviance- a commonly understood phenomenon when looking at substance use disorders- identified behaviours, thoughts, and feelings that were previously framed as sins or crimes, as medicalized psychiatric disorders (Anderson et al., 2010). While the shift from sin and deviance was a positive shift forward, as it initiated the creation of the American Psychiatric Society's Diagnostic and Statistical Manual (DSM) in 1952, which turned towards the medicalization of patterns of behaviours and mood, this shift presented its own distinct problems (Shostak et al., 2008). The DSM is considered to be the gold standard guide for the classification of mental health disorders used for clinical, research, and policy in North

America. Its recognition and widespread reach influences the ways in which disorders are diagnosed, treated and investigated (Shostak et al., 2008). As such, the clearest example of the medicalization of substance misuse is the DSM.

In 1952, the first DSM (DSM-I) conceptualized substance use as arising from a primary personality disorder and used the labels "alcoholism" and "drug addiction" (Robinson and Adinoff, 2016). In the later iterations, DSM used terms such as "substance dependence" and "substance abuse". Since the 1960s, "substance abuse" has been the most commonly used umbrella term for substance use and "substance abuser" used to describe persons with alcohol and substance related problems (Abuse et al., 2016). The terms "abuse" and "abuser" are historically rooted in religion and morality concepts, often used to characterize people with violent, irrational behaviour, and were therefore highly stigmatizing terms (Abuse et al., 2016). As research and science increased our understanding of the biological and genetic roles which contribute to addiction, these terms began to be considered as inaccurate representations (Kelly, Saitz and Wakeman, 2016). It wasn't until the most recent iteration of DSM-V in 2013, that the term "addiction" was recognized as an ambiguous and stigmatizing term, and was therefore removed (Robinson and Adinoff, 2016). The DSM-V also removed the abuse-dependence paradigm, as medical understandings of mental health disorders advanced (Robinson and Adinoff, 2016; Botticelli and Koh, 2017). These changes were due to evolving social norms and increasing knowledge in the field of mental health and psychiatry, and a movement away from the perception that substance misuse issues were indications of other underlying primary psycho- and bio-pathologies (Robinson and Adinoff, 2016). According to the DSM, a diagnosis of SUD requires a significant degree of substance misuse, with an individual displaying at least two or

three out of eleven symptoms for a mild substance use disorder classification, four or five for moderate, and six or more for severe classification of a SUD (Hasin et al., 2013).

However, the concepts have evolved significantly and have since developed to capture the attention of health, social, and political policies- not just medical. As a result, since the 1970s, opposition in North America about stigmatizing language to frame addiction and substance use as medical and moral issues have existed in the field of addiction, however there was lack of scientific evidence to support the opposition (Kelly, Saitz and Wakeman, 2016). In recent years, evidence has shown a link between stigmatizing language and negative bias towards individuals with SUD (Kelly, Saitz and Wakeman, 2016). Stigmatizing words have the potential to implicitly evoke negative and punitive perceptions and also create barriers for individuals to seek support or treatment for their substance use issues (Kelly, Saitz and Wakeman, 2016).

In response to research and advocacy around stigmatizing language in substance use discourse, medical associations, scientific journals, government agencies and people who use substances, have called to further change the language. For example, Mr. Michael Botticelli, in his term as the director of the White House Office of National Drug Control Policy (ONDCP) in 2016, promoted replacing commonly used stigmatizing terms with terms that are more descriptive, as our social and medical understanding of substance use evolves. His last public document, entitled "Changing the Language of Addiction" was developed in consultation with a variety of stakeholders to ensure less stigmatizing language was adopted (Botticelli and Koh, 2016). For instance, rather than "drug abuser" they use "person with a substance use disorder"; "clean" with "in recovery" and discourages use of the word "drug habit", as it implies that substance use is a

personal choice (Botticelli and Koh, 2016). Recently, the Public Health Agency of Canada (PHAC) (Public Health Agency of Canada, 2020a) drafted a primer for Canadian health professionals and health organizations to also shift away from stigmatizing language. The guiding principles which inform the shift in language are: the recognition that individuals are complex and have unique life experiences, acknowledgment that substance use disorder is a medical condition and not an individual choice or moral failing, the important role of social determinants of health, and focus on empowerment and resilience approaches in treatment dialogues (Public Health Agency of Canada, 2020a). While these guidelines are not binding, and up to each organization and service to decide its uptake, it serves as an important tool in shifting the perceptions and discourse around substance use framing.

Although there is no consensus on what terms should be used when it comes to substance use discourse, the Global Commission on Drug Policy (2017) recognizes the need to minimize stigma and eliminate negative biases in language (O'Dowd, 2018). As the field of substance use continues to identify empowering and positive language, the term substance use disorder remains the most-scientifically accurate and non-stigmatizing term (Ashford et al., 2019). As such, it is clear how discussions around defining terms related to substance use have evolved from historical and traditional perspectives to contemporary and more inclusive discussions. However, while I have difficulty in wholeheartedly accepting this term as the most appropriate terminology, I continue to use it because it is the common language used in the field and is consistent with the DSM-V.

Having clarified key concepts in my investigation, I shall lay out my three goals of my research:

1. To critically assess the experiences of frontline youth service providers to shed light on their perspectives on substance use patterns, service provision and challenges faced by youth who use substances.

2. To critically evaluate the national level strategy document, the Canadian Drugs and Substances Strategy (CDSS), given its key role in informing practice at the provincial level, with a focus on how it incorporates, or fails to incorporate, the role of the social determinants of health, and appropriate and effective interventions in substance use among youth.

3. To appraise the policy implications of the tensions between dominant representations of substance use and the lived perspectives of frontline workers in the field of substance use for policy, practice and equity.

To achieve these goals, my dissertation, as mentioned earlier, involved three stages of data collection. First, I conducted a province-wide survey of service providers from youth-oriented addiction and/or problematic substance use treatment organizations in Ontario. Second, and in order to probe survey answers, I conducted key informant interviews with a small sub-sample of service providers (who indicated in the surveys that they would be interested in participating). Third and last, I applied the critical policy approach 'What the Problem is Represented to Be' or WPR (Bachi, 2012a) of the Canadian Drugs and Substances Strategy (CDSS) to assess how

substance use is represented as a problem and what this representation leaves out when assessed against the experience of frontline providers. Since the CDSS is the leading substance use guidance document in Canada, it is imperative to take a deeper look at how this document forms and contributes to the popular discourse around substance use, how it impacts provincial policy-making related to service provision, and to examine how it represents the 'problem' of substance use. While I was hoping to analyze a youth-specific policy, such a highly endorsed and recognized strategy does not exist at either the national or provincial level.

Overall, surveys and interviews of service providers who work with youth revealed significant gaps between theory and practice. While frontline providers expressed the need for more harm-reduction, non-pharmacological and prevention initiatives, the CDSS downplayed this need, as well as the significance of the SDOH, while largely framing the behaviours of substance users as falling under the jurisdiction of the criminal justice system. The WPR analysis revealed that prominent guiding frameworks largely criminalize substance use by construing it as predominantly falling under the jurisdiction of legal and enforcement mechanisms, thus perpetuating the stigmatization of the affected population. Thus, this leading policy document not only fails to address issues prioritized by frontline workers, it also fails to align with the idea of substance use as a public health issue, which in turn disadvantages youth who require specific support for their use. While the public health framing of substance use is becoming increasingly popular and the four-pillar approach is documented and endorsed within the CDSS, my analysis revealed that the CDSS is implicitly at odds with the four-pillar approach in terms of implementation.

After this introductory chapter, in which I set the stage for my investigation and define key concepts and their historical evolution, chapter 2 offers a review of the literature on substance use and the relationship between substance use and the social determinants of health, chapter 3 examines key policy responses and frameworks, chapter 4 elaborates on the health equity and SDOH frameworks that guided my research and outlines the methodological approaches used to conduct my investigation, chapters 5 to 7 lay out my findings, and chapter 8 outlines the policy implications of my findings and offers recommendations for policy and practice with the potential to promote greater health equity for youth who use substances.

Chapter 2: Literature Review

With an understanding of concept definitions, this section will look at substance use rates among youth populations internationally, nationally and provincially; the social determinants of health (SDOH) and the connection between substance use and mental health. It will become apparent that while the general landscape of substance use rates among Canadian youth have been documented over time in studies such as the Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS), Cohort study on Obesity, Marijuana use, Physical activity, Alcohol use, Smoking and Sedentary behavior (COMPASS), and the Ontario Student Drug Use and Mental Health Survey (OSDUHS) gaps still exist. In order to fill these gaps, there is the need to explore the relationship between substance use and the SDOH, as well as the relationship between substance use and mental health. The various factors related to the SDOH will shed light on the reasons as to why it is imperative that service providers are responding appropriately and effectively when faced with youth clients whom use substances, understanding different contextual situations.

Since epidemiological data is the most commonly used form of research which drives substance use conversations and public policy, it is important to understand these numbers. The following section will provide a landscape of youth substance use rates internationally and nationally.

Understanding the Landscape of Youth Substance Use

Substance use among youth is not a new phenomenon and these rates have been documented internationally and nationally. Youth substance use differs from adults, not only in general use patterns and substances used, but also in the factors associated with use. According to Malla et

al., youth is defined as 12 to 25 years, because they encompass early adolescence and emerging adulthood (Malla et al., 2018). The World Health Organization (WHO) defines 'adolescents' as individuals in the 10-19 years' age group, 'youth' in the 15-24-year age group, and 'young people' cover the age range of 10-24 years. The 10-24 age range takes a pragmatic approach of combining the two age ranges of adolescents and youth into an all-encompassing range (World Health Organization, 1986). The Canadian Federal Government also uses different definitions of youth, whereby Statistics Canada defines youth as 16-28, and Human Resources Skills and Development uses ages 15-24 (Age limits and adolescents, 2003). As such, there is no universal agreed-upon age-range for adolescence or youth. The next section will present data documenting youth substance use in the international, national and provincial context.

International Trends

In 2013, alcohol and illicit substance use among adolescent men (aged 20-24) were responsible for 14% of their total health burden, while the burden attributable to substance use increases substantially in adolescence and young adulthood in the United States (Degenhardt et al., 2016). Most research suggests that early (12-14 years) to late (15-17) adolescence is an important risk period for the initiation of substance use and use peaks among those 18-25 (SAMHSA, 2014). Cannabis is a common substance of choice for young people based on evidence from Western countries, where youth reported that they perceived easy availability of cannabis and low risk of harm. In high income countries, substances such as ecstasy, methamphetamine, cocaine, ketamine, LSD, and GHB are commonly used among youth. Among street involved youth, the most commonly used substances are inhalants (paint thinner, petrol, paint, correction fluid and

glue) (World Drug Report, 2018). The substances they use are often selected for their low price, legal and widespread availability and ability to rapidly induce euphoria.

North American Trends (Canada, U.S., Mexico)

According to the 2018 National Survey on Drug Use and Health, 4,200,000 (or 16.7%) youth (aged 12-17) used any illicit substance in the past year, with 3,100,000 (or 12.5%) using cannabis, 112,000 (or 0.4%) using cocaine, 699,000 (or 2.8%) using opioids (SAMHSA, 2019). Nationally representative data from the United States indicates that past-month, past-year, and lifetime marijuana use has remained stable among high school students with 6.6% of 8th grade, 18.4% of 10th grade, and 22.3% of 12th grade students reporting past-month marijuana use (2019), with daily use increasing among 8th and 10th (Johnston et al., 2020). Additionally, 2.7% of 12th graders reported using prescription opioids (other than heroin) in the past year (2019); 0.4% of 12th graders reported past-year heroin use; 2.2% of 12th graders reported past-year cocaine use; methamphetamine was less than 1% across all grades (Johnston et al., 2020).

Past year prevalence of marijuana use among secondary school students in North America was highest in the US (22.6% in 2016) followed by Canada (over 15%; 2014/2015), then Mexico (9.1% in 2014) (Ahumada et al., 2019). Prevalence of inhalant use among secondary students in North America is 2.5%, in Canada past year inhalant use is 1.4% between 2014-15 (the lowest among North American countries), with Mexico reporting the highest prevalence (3.9%) in 2014 (Ahumada et al., 2019). In North America, Canada has the highest past year use of cocaine compared to U.S. and Mexico (Ahumada et al., 2019). In North America, prevalence was 1.2%, while Canada reported prevalence of 2.6% between 2014/2015 and US reported 1.4% in 2016

(Ahumada et al., 2019). Cocaine use is similar among male and female secondary school students in Canada, while in Mexico and US the gender gap is larger (Ahumada et al., 2019). In North America, Canada has the highest rate of ecstasy in secondary school student; 2.8% in Canada between 2014/2015 and 1.8% in US in 2016 (Ahumada et al., 2019).

When looking at trends among youth in the U.S. (grade 8th-12th) between 2018 & 2019: 38% reported any illicit substance use in 2019 (including marijuana) and 11.5% excluding marijuana; marijuana (35.7%), LSD (3.6%), Cocaine (2.2%), MDMA (2.2%), Heroine (0.4%) among 12th graders (NIDA et al., 2019). Grades 8 (0.7 to 1.3%) and 10 (3.5 to 4.8%) reported significant increase in daily marijuana use between 2018 and 2019 (Johnston et al., 2020). In 2019, Adderall misuses (ADHD medication) significantly decreased among grade 10 and 12th graders, but increased in 8th graders compared to 2014 (NIDA et al., 2019). Vaping was 11.7% and represents a significant increase, while alcohol use continues to decline, however higher among higher grades (NIDA et al., 2019).

National Trends

As of 2019, there were over 7 million youth across Canada, aged 15 to 29 (Statistics Canada, 2020). Recent Canadian surveys have shown that tobacco, alcohol and cannabis are among the top substances frequently used by youth (Government of Canada, 2019b). In 2017, past-year use of illegal substances was 396,000 (or 20%) among youth aged 15-19, and 816,000 (or 35%) among those aged 20-24 (Government of Canada, 2019c). Specifically, 390,000 (or 19%) of youth aged 15-19 used cannabis in the past year, and 780,000 (or 33%) of youth aged 20-24 used cannabis in the past year (Government of Canada, 2019c). Past-year use of either cocaine/crack,

ecstasy, speed/methamphetamines, hallucinogens or heroin, while relatively low in comparison to the entire population, was (81,000 or 4%) among youth aged 15-19, and 241,000 (or 10%) among those aged 20-24 (Government of Canada, 2019c). Approximately 332,000 (or 17%) of youth aged 15-19 reported past year psychoactive pharmaceutical use, and 492,000 (or 21%) of those aged 20-24 reported past-year psychoactive pharmaceutical use (Government of Canada, 2019c). 59% of youth aged 15-19 reported using alcohol in the past year. Cannabis was the second most commonly used substance among youth in Canada (15-25), after alcohol. In 2015, 30% of those aged 20-24 years reported use within the past year (Government of Canada, 2019b). Moreover, opioid related hospitalizations have rapidly increased in the past 5 years among youth ages 15 to 24 from 7.1 per 100,000 in 2010-2011 to 12.4 per 100,000 in 2015-2016 (Government of Canada, 2019b).

Youth Substance Use in Ontario

Substance use among youth in Ontario is pervasive. Ontario is home to approximately 2.95 million youth between the ages of 15-29, which make up an extremely diverse population (Statistics Canada, 2020). Substance use rates are commonly elevated among youth and young adults, as rates of substance use also increases through high school and into adulthood (Henderson, Chaim and Brownlie, 2000). With regards to specific substances, the OSDUHS survey provides the most recent and up-to-date statistics on usage. The top four substances used in the past year by Ontario students were: 41.7% alcohol; 22.7% e-cigarettes; 22% cannabis; and 11% non-medical use of prescription pain relievers such as codeine, Percocet, Percodan, Demerol, or Tylenol (Boak et al., 2020).

The most recent OSDUHS survey among grade 7-12 (age 10-18 years of age) documented the following trends. Past year use of electronic cigarettes (vapes) significantly increased from 10.7% in 2017 to 22.7% in 2019 (Boak et al., 2020). Past year use of tobacco cigarettes declined (7% to 5%), waterpipes (6.2% to 4.4%) and ecstasy (MDMA) (3.4% to 2.3%) decreased between the years 2017 and 2019 (Boak et al., 2020). Illicit substance use has remained stable since 2017 (Boak et al., 2020). First time use of illicit substances has been stable since 2017 with 3% of students grade 7-12 reporting first time use (Boak et al., 2020). Since 2007, significant increases in nonmedical use of ADHD medication (1% to 2.7%) were reported (Boak et al., 2020). Both males and females reported a significant increase in the use of electronic cigarettes since 2017 and nonmedical use of ADHD medications since 2007 (Boak et al., 2020).

With regards to tobacco use, in 2019, 5% of students in grade 7-12 reported smoking more than just a few puffs of tobacco cigarettes during the past year and 2% reported smoking cigarettes daily (Boak et al., 2020). Males (6%) are significantly more likely than females (4%) to smoke tobacco cigarettes (Boack et al., 2020). The prevalence of cigarette smoking significantly increased with grade, with 11% reported among 12th graders (Boak et al., 2020). While males and females are equally likely to use e-cigarettes, use significantly increases with grade from 2% among 7th graders to 35% among 12th graders (Boak et al., 2020).

In terms of alcohol use, past year use of alcohol significantly varied by grade with 7% in 7th graders and 66% in 12th graders (Boak et al., 2020). 28% of students reported drinking alcohol in the past month. 15% in grade 7-12 reported binge drinking at least once in the past month, and males and females are equally likely to binge drink and get drunk (Boak et al., 2020). 14% of

high school students reported hazardous drinking, and this trend increased with grade (Boak et al., 2020).

When looking at cannabis use, in 2019, 22% in grade 7-12 reported using cannabis in the past year (Boak et al., 2020). There was no significant change reported in cannabis use since 2017. Use did not significantly vary by sex, however it increased with grade from 1% in grade 7 to 40% in grades 12 (Boak et al., 2020). 3% of high school students reported symptoms of cannabis dependence (Boak et al., 2020). When looking at non-medical use of prescriptions, past year nonmedical opioid use remains stable since 2017, but lower than 2007 when monitoring began (Boak et al., 2020). In 2019 (11%) vs. 2017 (10.6%); in 2015 it was 10% (Boak et al., 2020).

OSDUHS documented overall substance use problems, whereby 15% of high school students reported symptoms of a substance use problem, which has been relatively consistent in recent years, but is currently lower than estimates over a decade ago (Boak et al., 2020). 0.7% reported they were in a treatment program during the past year due to substance use (Boak et al., 2020).

Overall, it is important to note that strictly epidemiological data, which is commonly cited and usually at the forefront of public discourse when discussing substance use issues, does not commonly take into account the social context. Epidemiological data alone does not provide a full picture that qualitative data can contextualize, which is why the integration of the SDOH is critical in discussions around substance use, and will be examined closely in the next section.

Social Determinants of Health (SDOH)

The SDOH concept has emerged as a popular approach in understanding and describing different health outcomes that move beyond biomedical and behavioural risk factors (Braveman and Gottlieb, 2014). Social determinants of health are one of the relevant tenants of health promotion and are closely intertwined with the factors that contribute to behaviours and decision making. According to the World Health Organization (WHO), social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels and ultimately influence health (Commission on Social Determinants of Health, 2008). Determinants of health may include, but are not limited to economic stability, neighborhood, health and health care and education (Raphael, 2008). The source of health inequities is mainly attributed to a lack of access to basic goods and services, whereby certain populations are disadvantaged in comparison to other privileged groups within society (Raphael, 2008).

The recognition of the need to address social, economic and environmental determinants of health has become more demanding globally. The Commission on the Social Determinants of Health was developed by the WHO in 2005 to more effectively address issues related to health equity. The SDOH framework has been characterized as the economic and social conditions that shape(s) the health of individuals, communities, and jurisdictions as a whole (Raphael, 2011). More specifically, the WHO has stated that "these inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces" (Commission on Social Determinants of Health, 2008, pg. 3). Key social determinants of health include: Indigenous status, income and

income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, housing, social exclusion, social safety network, health services, gender, race, and disability (Raphael, 2009). Health care is also considered a social determinant as it is influenced by social policies and directly influences the health of individuals. This is because health care is related to allocation of resources, health services (including substance use services) and the quality of health services provided to citizens, which is all dependent on the government and welfare state (Braveman and Gruskin, 2003).

It is widely recognized that determinants of health are often at the root of substance use issues (Spooner and Hetherington, 2005). While the rates of substance use may vary depending on certain political, economic or social factors, those who experience substance use issues are disproportionately comprised of people who identify with marginalized or vulnerable groups, who are more significantly impacted by their SDOH (Raphael, 2008). The next section will briefly look at the relationship between substance use and marginalized populations.

Substance Use and Marginalized Populations

Interest in the growing health inequalities and inequities that populations marginalized through unequal power relationships across social, political, economic and cultural dimensions (e.g. poverty, homelessness) face in Canada has prompted further research to understand the risk factors that could contribute to poor health and risky substance use (Given, 2008). Marginalized groups experience a disproportionately high level of social factors that could negatively affect their health- factors such as social and economic aspects that shape behaviour, racism embedded within policy, institutional racism, or inequitable services (Gee and Ford, 2011). Some examples

of marginalized populations include, but are not limited to, immigrant populations; incarcerated individuals; people of low socioeconomic status; people with disabilities; Indigenous populations; women; or children and youth (Mohajer and Earnest, 2010). Marginalized populations are often considered as those excluded from mainstream social, economic, cultural or political life (Sevelius et al., 2020). These marginalized groups face different forms of exclusion and issues, depending on the varying social determinants of health. However, as a common denominator, they experience higher rates of vulnerability, which in turn may negatively impact their health status and behaviour. Furthermore, specific policies can perpetuate marginalization as well as issues within services that do not provide an equitable framework such as not being able to accommodate for certain demographic populations (e.g. language), or not addressing gender or culture in care structures (Braveman and Gruskin, 2003).

Indigenous Populations and Substance Use

While the focus of my dissertation is on youth, it is important to recognize the disproportionate impact of substance use on Indigenous youth populations, an extremely marginalized population (Sikorski, 2019). Indigenous youth are one of the fastest growing populations in Canada; however, they are also close to the top of the list of Canadians whom are most likely to die (Gracey and King, 2009). According to a 2017 community-based study entitled the Cedar Project, one of the major reasons causing an increased mortality rate of Indigenous youth is attributed to increased substance use (Jongbloed et al., 2017). There is strong evidence to suggest that Indigenous youth are more likely than other Canadian youth to use tobacco, alcohol and marijuana (Jongbloed et al., 2017). For instance, based on the results of a cross-sectional Canadian survey (CSTADS), Indigenous youth had more than five times higher odds of being

smokers compared to non-Indigenous youth; and Indigenous youth, especially male youth, drank alcohol and used cannabis starting at a younger age compared to their non-Indigenous youth counterparts (Sikorski et al., 2019). These numbers have been longstanding and represent a pattern in substance use among Indigenous youth populations. For instance, based on data from the 2008/2009 national Youth Smoking Survey, the prevalence of current smoking among the Indigenous youth population was more than double compared to non-Indigenous youth (24.9% versus 10.4%) (Elton-Marshall et al., 2011). Moreover, when compared to non-Indigenous youth, Indigenous youth were more likely to have higher prevalence of smoking, have high rates of binge drinking and were more likely to use marijuana (Elton-Marshall et al., 2011).

There are many reasons as to why this population is at a higher risk, which include discrimination, intergenerational trauma, financial issues, marginalization or trauma. There is significant evidence to document the different social determinants of health and its impact on substance use among Indigenous youth. Experiences with colonization and historical trauma have contributed significantly to the elevated risk of mental health issues and substance use problems among Indigenous people (Truth and Reconciliation Commission of Canada, 2015). And as a result of these issues, they often experience major social and economic challenges related to the determinants of health such as inequitable access to health care, poverty, and high unemployment (Truth and Reconciliation Commission of Canada, 2015). In fact, being Indigenous is considered a determinant of health, as those who are Indigenous face and experience distinct factors and determinants than that of their non-Indigenous counterparts (Greenwood and de Leeuw, 2012). Furthermore, Indigenous Peoples experience systemic discrimination in the health care system which negatively impact the quality of care they receive

(Allan and Smylie, 2015). As discussed in the report *First Peoples Second Class Treatment (2015),* at the individual, family and community level, Indigenous populations have been managing racism and its impacts on health for hundreds of years (Allan and Smylie, 2015). In fact, the case of Brian Sinclair, a 45-year-old Indigenous man who fatally died in an emergency department in Winnipeg in 2008, is a clear example of racism in the health care system; whereby the health care workers from the hospital admitted to assuming Sinclair was drunk or homeless (Allan and Smylie, 2015). The more recent case of the death of Joyce Echaquan in Quebec is another devastating illustration of the prevalence of racism against Indigenous People in the health care system (Olivier, 2020).

Due to the distinct factors that impact Indigenous substance use, it is clear that the approaches needed to support Indigenous youth who engage in substance use is different than the services or approaches used in supporting the general youth population. There is clearly a need for culturally appropriate programming when working specifically with Indigenous youth, as well as ensuring that systemic discrimination and racism is eliminated from the health care system (Allan and Smylie, 2015). As such, the consideration of youth substance use among Indigenous youth is multifaceted and requires an extensive examination of the intersectionality of multiple determinants of health, as well as specific factors which relate to inequities within the social, political and health context generally, which is beyond the scope of my dissertation.

With an understanding of the ways in which certain marginalized communities are impacted by the SDOH, I will now present how SDOH interplay with substance use and how youth- as a specific marginalized population-are impacted by the SDOH.

Social Determinants of Health and Substance Use

Since substance use during teenage years is highly predictive of a wide variety of problems that occur later in life, there has been significant research focused on the risk and protective factors for adolescent substance use, including the environments in which they are exposed to while growing up (Wright and Pemberton, 2004). According to this framework, substance misuse is considered to be driven by a complex interaction of social determinants of health. These include changes to the social, cultural, economic and physical environments (Abuse, 2016a). As such, in order to understand and develop appropriate policies and services to respond to substance use issues among youth, it is imperative to look at the ways in which SDOH may initiate or perpetuate substance use. The next section will look at how different social determinants of health relate to youth substance use, as multiple determinants impact and influence an individual's decision to engage in substance use (Schreier and Chen, 2013). Depending on the individual, and the position they are in life, different determinants will impact them differently.

While all determinants of health are relevant and must be considered when looking at youth substance use, for the purpose of the dissertation, I will focus on: age, early childhood, housing, race, gender and socioeconomic status. Research has shown that these determinants play a strong role in impacting substance use, as social and economic factors have proven to shape risk behaviour and the health of those who use substances (Galea and Vlahov, 2002). More specifically, The *Conceptual Framework of the Determinants of Substance Misuse* organizes risk and protective factors at the individual, family, community and societal levels- which include age as a person develops; relationships at the family level, including early childhood; school and neighborhood environments, including peer groups; and socioeconomic factors (Solar and Irwin,

2010). Youth substance use patterns are continuously evolving as different substances fluctuate in popularity. While trends of use have varied overtime, experts have agreed that a cumulative number of risk factors contribute to the reasoning's as to why youth use (CCSA, 2007). The role of specific determinants of health and their relationship with substance use will now be examined in more detail.

Substance Use and Age

Among the determinants of health, age is unquestionably associated with risk of use and misuse and is especially relevant for my dissertation. It has been documented that generally, substance use increases with age (CCSA, 2007). Substance use among adolescent's ranges along a continuum from experimentation to substance use disorder (City of Toronto. 2020b). For many young people, using substances is simply part of the process of growing up. However, evidence shows that the earlier in life that one starts using substances and the greater frequency of their use, the higher the risk for substance use disorders (Jordan and Anderson, 2017). Adolescence and young adulthood are key life stages when behaviours and habits become established. During this time, many youth may experiment with substance use; however, some develop harmful habits that carry into adulthood (Jordan and Anderson, 2017). Adolescents are vulnerable to the effects of substance use and are thus at an increased risk of developing long-term consequences as a result of use, such as mental health or substance use disorders (Schulte and Hser, 2014). Adolescence brings on many social and physical changes, whether that is puberty, coping with new relationships, and evolving independence. Interpersonal factors related to family are also associated with substance use (Backes and Bonnie, 2019). Based on nationally representative longitudinal data from the United States, alcohol use, smoking and cannabis use patterns

increased from early adolescence, reaching the highest level around mid-20s, and declining thereafter (Robards et al., 2018). The identification that substance use increases with age was also documented in 2008 from another nationally representative sample of students (grade 7-12) across 10 Canadian provinces, where substance use increased with age, with grade 12 students reporting higher prevalence than those in grade 7 (Leatherdale and Burkhalter, 2012).

Substance Use and Gender

Gender is also an important demographic characteristic associated with substance use. Gender differences in substance use is evident, as well as differences in specific substance use behaviours and patterns (Becker, McClellan and Reed; 2017). It is clear that adolescent males and females differ in terms of lifestyles, chronic stressors and life experiences, which all influence substance use patterns among them. Studies show the differences in use and outcomes, and these differences are also relevant as youth grow older (US Department of Health and Human Services, 2016). For instance, men are more likely than women to use almost all types of illicit substances, and are more likely to result in emergency department visits or overdose deaths for men in comparison to women. For most age groups, men have higher rates of use or dependence on alcohol and illicit substance than women (Abuse, 2016c). However, research has indicated that females are just as likely to develop a substance use disorder, as well as be more likely to relapse in comparison to males (Anthony et al., 1997; Kippin et al., 2005).

Based on a National Longitudinal Study of Adolescent youth between the ages of 12 and 34 years, females showed higher levels of substance use than males during early adolescence. In contrast, males showed higher levels of substance use from middle adolescence to early adulthood. Higher levels of substance use in males persisted from middle/late adolescence

through young adulthood (Chen and Jacobson, 2012). Based on the 2008-2009 Canadian Youth Smoking Survey, among grade 7-12th students in Canada, males were more likely than females to report current alcohol, marijuana, and tobacco use (Leatherdale and Burkhalter, 2012).

Research has also demonstrated that women typically use and respond to substances differently. They also face distinct obstacles when seeking treatment that men do not experience, such as finding childcare for their children when accessing treatment. There are also gender differences in the long-term impact of substance use (NIDA, 2020b).

Substance Use and Early Life

The influence of family on adolescent substance use has been well documented in both the scientific and grey literature (Andrews et al., 1993). At the family level, relationships can undoubtedly influence a youth's decision to engage in substance use. Many studies have in fact pointed to parental relationships as the most important protection against the development of an early addiction among youth (Robertson, David and Rao, 2003). Parenting styles and practices, as well as relationships can serve as factors that influence one to use substances (Robertson, David and Rao, 2003). Generally, positive family influences, such as family bonding, and consistent house rules appear to be related to the reduced use of substance use among teens. The quality of parent and children relationships likely influence decisions and behaviours made by youth, including their choices to use substances (Rusby et al., 2018). Conversely, youth may experience lack of parental/guardian involvement, neglect, or negative role modelling which all serve as factors that potentially could drive substance use. Negative role modeling can include parental modeling of substance use or parental attitudes that are favorable of substance use (i.e.

parents purchasing alcohol for underage children) (Measelle et al., 2006). Data from a longitudinal study examining social influences on risky behaviours during early to mid-adolescence, including substance use, indicated that both poorer parent-youth relationships and lower parental monitoring were associated with alcohol and marijuana use, and binge drinking (Rusby et al., 2018). Also, good quality parent-child communication about substance use predicted lower levels of substance-use problems (Lander, Howsare and Byrne, 2013).

There is also evidence that behavioural modeling of substance use through exposure to parental or family use early in life also has an impact on youth (Shakya, Christakis, and Fowler, 2012). It has been argued that adolescents are more likely to engage in substance use if their parents are accepting and tolerant of it, engage in substance use themselves, or don't perceive such behaviour to be risky or problematic (Cambron et al., 2019). Parental binge drinking also predicted youth alcohol initiation and reporting of poor-quality parental relationships predicted marijuana onset (Rusby et al., 2018). Another qualitative study from Northern Ireland indicated that parent and child attachment and effective parenting were identified as important factors in preventing adolescents from substance use (McLaughlin, Campbell and McColgan, 2016). Additionally, early exposure to substance use was viewed as harmful for the youth, since it normalizes the ways in which children view substances (Mason et al., 2013).

In addition to parent-child relationships, when children don't have a stable and loving home environment, they may develop unhealthy behaviours, often termed as adverse childhood experiences (ACES). ACES are also associated with increased engagement in substance use (Brown and Shillington, 2016). Adverse childhood experiences can include stressful and/or

traumatic events such as neglect; mental, physical or emotional abuse; family dysfunction and exposure to violence and crime (Pederesen et al., 2018). Child welfare-involved youth are among the populations that experience intensified ACES, which contribute to the factors that may initiate their use. According to a study in the United States between 1998-2001, illicit substance use was reported more frequently among those in child welfare in comparison to those that weren't (Jaycox, Morral, and Juvonen, 2003). Additionally, data based on a national longitudinal survey of child and adolescent well-being further emphasized that youth in family welfare systems between the ages of 11 and 17, were at greater risk of using alcohol, marijuana, and polysubstance use. The study also documented that youth who had experienced physical abuse were also at greater risk of polysubstance use (Snyder and Smith, 2015).

Overall, it is clear that early childhood plays an important role on youth, especially in relation to substance use. Parent modeling, attitude, parental use, and adverse childhood experiences are all significant predictors of adolescent substance use initiation, and maintenance.

Substance Use and Housing

When understanding the social determinants of health, and the ways in which the inequitable distribution of income, power and resources influence health, it is notable to look at how housing and neighborhood impact on substance use among youth. Living in neighborhoods with low socioeconomic status, high unemployment, inadequate housing and higher crime rates, tends to be associated with greater likelihood of substance use (Settipani et al., 2018). Data from the longitudinal Seattle Social Development Project, indicated that youth living in

socioeconomically disadvantaged neighborhoods was associated with higher odds of past month cigarette smoking, binge drinking and polysubstance use among youth (Settipani et al., 2018). Research that analyzed neighborhood income and health have shown that neighborhoods with overall lower incomes, have high infant mortality rates, high suicide rates, high death rates and increased prevalence of diseases (Wilkinson, 2005). Another study conducted by Wilkins et al. (1989), found that individuals living within the poorest 20% of neighborhoods are more likely to die from diseases such as cancer, diabetes, heart disease and respiratory illness in comparison to those who have higher socioeconomic status (Wilkens et al., 1989).

Social integration and social influence within peer neighborhoods and physical environments also evidently play a role when youth decide to use (Boardman and Saint Onge, 2005). Social influence largely relates to peer groups and can include peer substance use. Peers have a huge influence in whether or not a youth decides to use substances (Boardman and Saint Onge, 2005). Their influence, could be argued as perhaps the most influential among this age group, as they not only spend the most amount of time with them, but could also feel more pressure to fit in and be accepted among certain peer circles (Ramirez et al., 2012). This ties into social integration and can include interpersonal alienation among their peer network.

Substance Use and Socioeconomic Status (SES)

Health outcomes, mortality rates, and incidence of disease strongly correlate with a person's position in the socioeconomic hierarchy (Marmot, 1993). Social hierarchy from a health perspective refers to a system by which individuals experience unequal circumstances in comparison to others in society (Lynch, 2000). This indicates that those who have more power,

income and opportunity experience better outcomes; and this is reflective across the social gradient. The term social gradient looks at an individual's susceptibility to poor health, which illustrates a link between health and socioeconomic status (Adler et al., 1994). Those who are at the lower end of this gradient, typically have lower SES, and as such have fewer resources available. As a result, these individuals are the most vulnerable and experience worse health outcomes (Dixon, 2000; Wilkinson, 2005). Studies have highlighted that among low-income youth, there was a significant interaction between family and resource stressors (poverty and material deprivation). Family-level stressors, such as negative relationships and interactions, was a strong predictor of substance use among youth, whom also had greater experiences of material deprivation (Booth and Anthony, 2015). Additionally, the study found a negative interaction between peers and poverty, suggesting that stronger peer relationships in neighborhoods with higher levels of poverty may present as a risk factor for use (Booth and Anthony, 2015).

Socioeconomic status is a fundamental cause of disease, and studies have indicated the existence of a social gradient, documenting how rates of morbidity and mortality decrease directly and proportionately with each increase in level of income or education (Adler et al., 1994). Although homelessness, unemployment, poverty etc. are commonly referred to as consequences of substance use, I consider them as social circumstances that are responsible for shaping health differentials among substance users, especially youth. While data specifically linking low SES to youth substance use is sparse, there is data which documents these associations among the general population. As such, I believe that this information can be applied to youth populations, as a factor that could potentially influence their decision-making to engage in substance use.

Low parental socioeconomic status has also been documented to be significantly associated with youth substance use (Patrick et al., 2012).

Substance Use and Race

Racial differences in health is prominent. While studies demonstrating the differing rates of substance use among different racial groups vary, there is a breadth of research which documents how race correlates with substance use patterns (Neblett et al., 2010). For instance, while African American youth have typically reported lower rates of substance use than their White counterparts, the consequences of their substance use in adolescence are often more negative and severe due to several factors, including their engagement with illegal behaviors or lack of access to appropriate services (Centres for Disease Control and Prevention, 2006; Johnston et al., 2007). While it is difficult to investigate the specificities between each race and the relation to substance use, there are some leading and common themes that can be discussed when thinking about race as a SDOH. Firstly, racial discrimination in the health care system is prominent among many different racialized populations. Generally, and not specific to substance use or youth, individuals who are members of racial and ethnic minorities are less likely to receive preventative health services and often receive lower quality health care, in comparison to their counterparts in the United States, as documented by the Institute of Medicine report entitled *Unequal Treatment* (Smedley et al., 2002). Perceived racial discrimination in health care is defined as individuals perceiving unfair and unfavorable treatment due to race (Assari et al., 2019). There is growing literature that demonstrates the relationship between perceived race-based discrimination and substance use outcomes (Hostetter and Klein, 2018). One study conducted with 105 Black adolescent girls between the ages of 11 and 19 found that 52% of girls

reported experiencing some form of discrimination, which was associated with their smoking habits (Guthrie et al., 2002). In a prospective study of 897 families with a child between the ages of 10 and 12, children's experiences of discrimination were associated with their current and future substance use, children's peers use, and children's perceptions on substance use risk taking (Gibbons et al., 2004). For some, racial discrimination had been directly linked to substance use, where studies have found relationships between reports of discrimination among Blacks and alcohol, tobacco and overall substance use (Borrell et al., 2007). For some, experiences of racial discrimination may trigger substance use, as discrimination is associated with greater use of alcohol and other substances (Otiniano et al., 2014).

Effects of Social Determinants of Health (SDOH) on Service Access and Use

Understanding the role SDOH play in shaping youth behaviour is not only important when exploring why youth decide to use substances but is also fundamental in looking at the impact it has on the ability for youth to access services for their substance use. A study by Settipani et al. (2018) reported that problems with SDOH are common among service-seeking youth. The majority of the youth whom participated in the study stated concerns in at least one SDOH domain (food security, living arrangements, finances and access to treatment), indicating that problems related to these determinants are likely to impact other youth that are seeking treatment (Settopani et al., 2018).

Combined effects of the SDOH result in barriers for young people to access, engage and navigate through the health care system. These include the inability to recognize and understand health issues, especially if they grow up in an environment where substance use is normalized;

structural barriers such as cost is present; and fragmentation of services, including the difficulty of navigating through the health care system is experienced (Andermann, 2016). Based on a systematic review of literature across multiple marginalized youth in the United States, Australia, Canada and the United Kingdom, it was identified that cost was a strong barrier for low income and homeless youth to access services (Robards et al., 2018).

The abovementioned SDOH indicate the ways in which these factors contribute towards youth decisions to use substances. Factors outside of their control often act as the driving forces that influence continued substance use and ultimately could lead to poor health outcomes. Substance use research places predominant emphasis on understanding substance use in relation to individual factors (Rhodes, 2009). By looking closely at the influences of the SDOH, one can advocate for policies and practices that acknowledge these complex circumstances that impact youth actions or behaviours.

Discussions around substance use are incomplete without the recognition of mental health issues, as they are more often than not, connected and related to the SDOH. Within the literature, there is a host of evidence that purports that substance use and mental health are linked and related to one another; however, disagreements on the intricacies of this linkage are common- with evidence for both (NIDA, 2020a). The next section will take a closer look at this relationship.

Substance Use and Mental Health Issues

The links between mental health and substance misuse issues are complex, and these issues might be developed independently as a result of factors related to the social determinants of

health, or one might lead to the other as a result of self-medication or prolonged distress (CCSA, 2013). People who experience mental health issues are more likely to also experience a substance use issue; and similarly, people who experience problems with substance use are more likely to be diagnosed with a mental health issue (NIDA, 2020a).

When mental health problems and substance misuse occur together, they are called concurrent disorders (also referred to as dual disorders, dual diagnosis, and/or co-occurring substance use and mental health issues) (Skinner et al., 2004). An example of a concurrent disorder is someone who suffers from chronic depression and is also an alcoholic. Mental health problems and substance use issues occur on a continuum, and a concurrent disorder emerges when they intersect at some point, resulting in many possible health, social, and economic issues (CCSA, 2013). The more severe the underlying individual mental health or substance use problem is, the more likely it will escalate to a concurrent disorder. It is estimated that people with mental illness are twice as likely to use substances compared to those in the general population (CCSA, 2013). Similarly, individuals who misuse substances have much higher rates of mental illness- approximately three times as high- than people in the general population (Rush et al., 2008).

According to the Centre for Addiction and Mental Health (CAMH), there are five main groups of concurrent disorders (Skinner et al., 2004):

1. Substance use with mood and anxiety disorders (e.g. depression or panic disorder);
2. Substance use with severe and persistent mental health disorders (e.g. schizophrenia or bipolar disorder);
3. Substance use with personality disorders (e.g. borderline personality disorder, or problems related to anger, impulsivity or aggression);

4. Substance use with eating disorders (e.g. anorexia nervosa or bulimia); and
5. Other substance use with mental health disorders (e.g. gambling and sexual disorder).

Mental health and substance misuse problems are common among youth (Kirst and Erikson, 2013). Adolescence is a time that brings about constant and dramatic changes, both independently and within social relationships. For some youth, the stress that accompanies these changes exceeds their ability to cope and thus contributes to mental health problems, substance misuse issues or both (Adair, 2009). Approximately one fourth (29%) of children and youth with mental health problems are estimated to have more than one mental health or substance use disorder (Waddell et al., 2014). In US studies, over half of youth who misuse substances meet criteria for at least one type of mental health disorder (Armstrong and Costello, 2002). Compared to youth who do not have concurrent disorders, youth with concurrent disorders present with more severe symptoms, have poorer treatment outcomes; are more likely to attempt suicide, and are more likely to experience significant and chronic social, economic and family difficulties and challenges (Grella et al., 2001; Kessler et al., 2005). While the service providers whom I engaged with worked with youth in the capacity of strictly substance use, it was clear that many recognized that mental health and substance use issues are interconnected, and underlying mental health conditions have the potential to play a role in substance use.

As a result of these longstanding high rates of substance use specifically among youth- and the recognition of the relationship between SDOH and substance use, the government has been pressured to respond; and many different approaches have been used to address these issues.

Before delving into the different policy responses to substance use, it is important to understand how health care services and programs are funded and delivered in Canada.

Chapter 3: Key Policy Frameworks to Substance Use in Canada

Each province and territory has legislation governing its health care system, which according to Canada's Health Act (CHA), provides universal, publicly funded access to physician and hospital services. As such, funding, administration and delivery of health services, are primarily the responsibility of the provinces and territories (Martin et al., 2018). However, the federal government plays an important role in providing financial transfers and support for provincial and territorial expenditures. The Federal Department of Health also sets national policy guidance and directives for epidemiological surveillance and other public health programs (Hyshka et al., 2017). This shared responsibility indicates that provincial bodies have the power to identify and guide policy-making and provide financial support to areas which they deem is necessary. They do not have to follow the federal government mandate or position and ultimately have the ability to make significant changes, especially in regard to substance use.

Both federal and provincial governments simultaneously play a significant role in the ways in which substance use issues are presented and addressed (Hyshka et al., 2017). The Federal government's role is to provide funding to the provinces and territories, leadership and support collaboration between and among organizations and agencies. They are responsible for laws and regulations regarding substances in Canada, as well as conducting research, increasing public awareness around substance use issues, and directly funds prevention, treatment and harm reduction services to specific populations, such as First Nations and Inuit, refugees, veterans, members of the military and people in federal prisons (Government of Canada, 2018a). Ultimately, the Federal government has control over the decisions regarding where funding should be used towards. On the other hand, each province has legislation governing its health

system; provincial and territorial governments are responsible for the implementation and delivery of prevention, treatment and harm reduction services (Hyshka et al., 2017). Due to the differences in roles and perspectives between the federal and provincial level, at times, political ideology rather than evidence has often shaped substance policy, as seen, for example, under the Conservative Harper government (2006-2015) and their agenda of "law and order" which greatly undermined harm reduction approaches to substance use.

More recently, clashes between the Conservative provincial government elected in October 2018 in Ontario and the Federal Liberal Government who was in power since 2015, over the support of harm reduction measures were evident. This change in provincial government went from a provincial Liberal government (2013-2018) who largely and openly supported harm-reduction policies, to a Conservative government who was strongly against harm reduction policies, such as supervised consumption services (Russell et al., 2020). In fact, the Conservative government announced that they were replacing supervised consumption services (SCS) and overdose prevention sites (OPS) with a different model, entitled 'Consumption and Treatment Services' (CTS). They justified this change by prioritizing treatment services over a harm-reduction approach, even though it contradicted the approach of the Liberal ideology to favor harm-reduction philosophies (Russell et al., 2020). As a result of these tensions and differences in approaches, access to harm reduction services across Canada vary incredibly based on jurisdiction, which reflects the provincial approach to substance use (Hyska et al., 2017). As a result, there is no universal and standardized approach or policy which speaks to the ways in which substance use issues should be addressed. Instead, the fragmentation of approaches at the federal and provincial level have encouraged an inconsistent dialogue and conceptualization on

how to appropriately respond. Ultimately, while good public policy development aims to benefit everyone, and responses which balance public order and public health concerns are supported and beneficial, inconsistencies in this balance exist. Since shared jurisdiction over health and the delivery of services between the federal and provincial government exist, provincial governments can articulate formal policy and funding commitments to services despite federal opposition (Hyshka et al., 2017). However, due to the differences between governments, it is difficult to adopt and implement a universal approach to address substance-related issues.

These tensions also exist at the federal level. With new governments coming into power, different approaches and policy responses have been adopted, which ultimately have a direct impact on substance use. This further amplifies the fragmentation and difficulty to implement universal policies that support the adoption of evidence-based frameworks rooted in principles of public health and harm reduction. For instance, the tension between Conservative ideology and effectiveness of service provision was also seen during the Harper Conservative government's attempt to shut down InSite in 2011, the country's first safe injection facility (Virdo, 2012), which will be discussed in greater detail shortly. Federal policy and legislation have guided health, political and social service responses, and some points in history have indicated the impediment of harm reduction and public health approaches from flourishing as Canada responds to the growing crisis. The next section provides a sequential timeline of the various policies that have been introduced in Canada from the mid 1800's to present day. It will become clear the shifting landscape of substance use from moral frameworks to medical frameworks and then towards public health approaches.

Evolution of Substance Use Policy Responses in Canada

In the 19th century when migrants from China started settling in British Columbia, they began to establish opium dens in their communities. The Canadian government viewed opium consumption primarily for medicinal reasons, as a relatively easy source to make money, whereby they imposed a tax on opium factories in 1867 (Riley and Nolan, 1998). Mackenzie King, the Minister of Labor at the time, was increasingly concerned with the growing number of opioid users, which is why he decided to implement the *Opium Act* of 1908. Under the Act, it was illegal to import, manufacture, or sell opium. Many have argued that the Opium Drug Act was the result of race, class, and gender tensions that led to legal and social discrimination against Chinese Canadians, as well as to support the criminalization of opioids (Boyd, 2018). Opium dens became the focus of police profiling (Boyd, 2018). However, this did not stop the production of opium through patent medicines, which caused the government to pass another Act called the *Proprietary and Patent Medicine Act*, which prohibited the use of cocaine in medications. With the imposition of the Opium Act, a black market for opioids emerged. Police enforcement believed that the only way to stop the black market from flourishing was to impose strict penalties through imprisonment. Parliament then passed the *Opium and Drugs Act* in 1911, where offenders would get harsher penalties for violating the law, including imprisonment- which began the "enforcement" phase of substance policy in Canada (Tooley, 1999).

The 1920s-substance policy was very different from the policy that is enacted in Canada today; substance users were considered more as criminals than those with a health issue. Enforcement has therefore traditionally been rooted in criminalization of substance use, and since there were no advocates for the treatment of substance use at this time, it was easy for enforcement

frameworks to dominate anti-drug legislation (The John Howard Society of Canada, 2003). In 1921, the penalties for drug offenders were expanded and by the end of 1923, more prohibited substances were included in the list of offences such as morphine, cannabis and cocaine. By the late 1940s, British Columbia had the most visible illegal substance using population nationally; and as a result, long prison sentences for possession offences and a high rate of recidivism was the most common outcome of Canada's punitive substance laws (Boyd, 2018). This period in Canada embraced an extremely criminalized and law enforcing framework, whereby substance use was captured under harsh anti-drug legislations consisting of law enforcement and criminalization. Until the late 1950s, law enforcement dominated Canada's policy orders, which some scholars have referred to as "one of the most punitive drug control systems in the world" (The John Howard Society of Canada, 2003, pg.26).

During the 1950's, the media used their power to publish highly dramatic and negative experiences of youth with substance use disorders in Canada (Solomon and Green, 1988). It was during this time, where the idea of providing treatment to substance users became significant. The conceptualization that substance use disorders and substance misuse should be considered as a social and medical problem, as opposed to a criminal issue emerged (Solomon and Green, 1988). Despite calls from the medical community to provide treatment for substance users, the 1961 *Narcotic Control Act* continued to focus on criminalizing substance use, even though there was the growing connection between substance use and public health during the 60s (Sinha, 2001). In 1969 the Commission of Inquiry into the Non-Medical Use of Drugs, also called the Le Dain Commission, produced four reports. All members of the commission vocally supported the movement towards the gradual withdrawal of the criminalization of illicit substances, including

the removal of imprisonment with possession, and that possession of cannabis should not be considered a criminal offence (Packer, 2004). During this period, the framework of criminalization and enforcement began to be challenged by the emerging 'public health' movement, whereby the gap between substance users and the general public narrowed significantly. The 'dope fiend' mythology, which was essentially the platform to enforce and instill criminalization and enforcement tactics, became condemned by the increasing number of youth engaging in recreational substance use without turning into 'criminals' (The John Howard Society of Canada, 2003). Essentially, this awareness called for a shift in the ways in which substance use was framed, as it was difficult to maintain myths that were not supported by reality. The laws around substances remained largely unchanged between 1969 and 1973 (Packer, 2004).

The substance use scare that dominated the discourse during the 1980s, which was mainly driven by politics and perpetuated by the media resulted in the launch of a five-year strategy. In 1987, the *National Drug Strategy* (NDS) was developed as a five-year federal initiative designed to address concerns regarding substance misuse in Canada (The John Howard Society of Canada, 2003). The Prime Minister at the time, Brian Mulroney declared that substance 'abuse' had become an epidemic, which undermined the economic and social display of Canada (Packer, 2004). The government acknowledged that substance misuse was primarily a health issue-shifting the landscape from a criminalization framework towards more of a public health framework. This new strategy included the four-pillar approach. It was a coordinated effort between the federal government, provincial and territorial governments, non-governmental organizations, professional associations, and international agencies. At the time, the Government

of Canada allocated approximately $210 million to support this new strategy, of which about 77% of funds was directed at substance reduction measures such as: education, prevention, treatment and rehabilitation i.e. the four-pillar approach (Packer, 2004). Before the implementation of this strategy, the approach from the federal government was almost entirely dedicated to supply reduction through enforcement, interdiction and control activities (Packer, 2004). The National Drug Strategy called for simultaneous and combined action in six specific areas: 1) education and prevention; 2) enforcement and control; 3) treatment and rehabilitation; 4) information and research; 5) national focus; and 6) international cooperation (Packer, 2004).

In 1992, the federal government renewed its commitment and launched a second phase of the strategy called *Canada's Drug Strategy* (CDS), a combination of the *National Strategy to Reduce Impaired Driving* and the *National Drug Strategy* (Torsney, 2002). In recognizing that a balanced approach at the national, provincial, territorial and community levels was needed, this phase focused on improving the knowledge base for making policy and program decisions; targeting resources to high-risk populations; and the provision of supplemental resources for federal substance misuse programs. The bill was also revised to lessen the penalties of cannabis possession for personal use; however, possession remained a criminal offence (Torsney, 2002).

In 1994, the *Controlled Drugs and Substances Act* (CDSA) was introduced by the Liberal Government as Bill C-8. This Bill created a number of new substance offences and extended the range of the law to include any substance with a "stimulant, depressant or hallucinogenic effect" (Riley, 1998). It also added new powers of search and seizure. Many organizations such as the Addiction Research Foundation of Ontario, the Canadian Police Association and the Canadian

Bar Association criticized the bill heavily for its 'war on drugs' approach, fitting in under the previous criminalization framework (Riley, 1998). In 1996, the *Controlled Drugs and Substance Act* was officially passed, and under this Act, substances were categorized into eight schedules: I to VIII. Punishment for trafficking illicit substances was included in schedules I and II, where offenders would get a maximum of life imprisonment (Riley, 1998). Penalties for the possession of substances were included in schedule VIII, and tough sentencing minimized the number of substance users. This Bill aimed to represent a significant shift in the discourse and perception of substance use. Many have argued that while this Bill was technically considered a 'health bill', its disciplinary focus evidently implied that it continued to symbolize the criminalization and enforcement frameworks, continuing to expand Canada's prohibitionist approach to substances (The John Howard Society of Canada, 2003).

In 1998, the federal government reaffirmed its commitment to the National Drug Strategy, and *Canada's Drug Strategy* (CDS) was created. The primary principle of the CDS was that substance use remained primarily a health issue. The long-term goal of the CDS was to "reduce the harm associated with alcohol and other drugs to individuals, families and communities" (Torsney, 2002, pg. 26), thereby recognizing the fact that the SDOH and other underlying factors must be considered and acknowledged when addressing substance use issues (Torsney, 2002). In 2003, the renewal of the federal substance strategy involved expanding commitments in four additional areas: leadership, research and monitoring, partnerships and intervention, and modernized legalization and policy. The year 2003 brought about another positive step forward for public health and harm reduction. In September 2003, under the Liberal government, North America's first safe injection facility known as InSite was opened, under the condition that it

would operate as a pilot site and be rigorously evaluated (Kerr et al., 2017). The Liberal government granted Vancouver Coastal Health Authority a limited exemption from Canada's substance trafficking and possession laws under section 56 of the CDSA. The exemption allowed Vancouver Coastal Health Authority in partnership with The Portland Hotel Society (later renamed PHS Community Services Society) to open up this site (Kerr et al., 2017). The evaluation of the site showed the effectiveness of reducing public disorder, overdose, infectious disease transmission and was successfully coordinating health service access and treatment to those who needed it (Kerr et al., 2017). The following year, Canadas Drug Strategy launched the Drug Strategy Community Initiatives Funds (2004) to provide financial support to projects that addressed issues related to substance use. Its goal was to develop local, provincial, territorial and national community-based solutions to substance use and to promote public awareness of problematic substance use (Hyshka et al., 2017).

Despite InSite's success, in 2006, in its final year of the pilot, the newly elected Conservative government came into power, led by Stephen Harper, and InSite was faced with the risk of closures. In response to the possibility of a closure, the PHS and InSite users filed a constitutional claim in the B.C. Supreme Court, claiming that InSite, as a health care facility, falls under the exclusive jurisdiction of the provincial government. The plaintiffs further argued that denying users the right to health services at InSite would subsequently infringe on the users right to life, liberty and security under section 7 of the Canadian Charter of Rights and Freedoms (1987) (MacDonald, 2011). After back and forth between PHS and the Federal government, and the support for the continued operation of InSite, the federal government went to the Supreme Court of Canada. Ultimately, the final case was heard on May 12, 2011 at the Supreme Court of

Canada. The decision was released on September 30, 2011, where all nine judges of Canada's highest court ruled unanimously 9-0, that attempts by the federal Health Minister to close InSite went against the country's Charter of Rights and Freedoms, by threatening the safety and lives of the people who relied on the site. This decision legitimized InSite as an effective and critical health care response to those struggling with injection substance use. It also created an opportunity for other jurisdictions in Canada to create similar services for substance users, as the Supreme Court order the Minister of Health to renew the exemption (MacDonald, 2011). The federal government responded by legislating more strict substance laws (Hyshka, et al., 2017). During the Conservative government's 10 years in power, support for harm reduction policies almost completely fell off the table. Canada's Drug Strategy was quickly replaced with a new *National Anti-Drug Strategy* (NADS). This new strategy officially removed harm reduction from federal policy and emphasized negative discourse around substance use generally (Hyshka et al., 2017). Even the name of the strategy itself 'anti-drug' proclaimed a negative connation, likely influencing the public to view substance use a certain way.

While the InSite case was being heard, and appeals were being made, Canada's first drug treatment court, the downtown community court was launched in Vancouver in 2008. It was a joint collaboration between the Ministry of Justice, provincial court of BC and 14 health and social services agencies. The community-based treatment court was based on intersectoral and multi-stakeholder frameworks to address the needs of the individuals it served (Garcia et al., 2019). Drug treatment courts aim to connect individuals to housing support, social services, employment counselling and culturally appropriate services. Its goal is to prevent the 'revolving door' pattern of substance related problems and to reduce prison costs and number of inmates.

By 2016, the newly elected Liberal government established the new *Canadian Drug and Substances Strategy* (CDSS), replacing the former National Anti-Drug Strategy, and gave responsibility of substance policy to the Department of Health. The CDSS guides the federal government's response to all substance use issues, including the opioid overdose crisis, and the move towards the legalization and strict regulation of cannabis (Government of Canada, 2018b). The new CDSS aims to apply a health lens to regulation and enforcement activities. The guiding principles of the new CDSS are: comprehensive; collaborative, compassion (substance use is a health issue and not moral one, recognizing that stigma can be harmful to people who use substances) and evidence-based practices. This strategy now included the four-pillars approach. CDSS is based on a comprehensive public health approach to substance use, aiming to address the root causes of problematic substance use (SDOH).

In 2017, the *Good Samaritan Drug Overdose Act* was passed to protect people at the scene of an overdose from select possession charges to encourage people to call 911 (Government of Canada, 2019e). Then in 2018, the *Cannabis Act* to legalize non-medical use of cannabis was passed into law, which included related amendments to the criminal code (Government of Canada, 2019d). In 2018, the Emergency Treatment Fund became part of the Budget, whereby there was a mutual agreement between the federal and provincial governments to improve evidence-based and access to treatment substance use services (Government of Canada, 2020).

Since May 2019, the CDSA began controlling precursor chemicals from importing and use in illegal production of substances that contribute to problematic substance use (Government of Canada, 2019d). Then, in October 2019, amendments were made to the *Cannabis Regulations*,

which governs the production, distribution and sale of cannabis products, to establish rules for the legal production and sale of 3 new classes of cannabis (edible, cannabis extracts, cannabis topicals) (Government of Canada, 2019d).

In 2020, a primer to reduce substance use stigma in the Canadian health system was introduced. The purpose of the primer is to mobilize health professionals and key stakeholders to take action to reduce stigma across the health system, recognizing how stigma drives and ultimately contributes to the social and health inequities (Public Health Agency of Canada, 2020). The primer offers recommendations for stakeholders in the health care system on strategies to reduce stigma, including infographics on non-stigmatizing languages. The primer focuses on three key messages: 1) Substance use stigma is prevalent throughout the health system and contributes to poorer quality of care and negative health outcomes; 2) Creating a stigma-free health system will require collaborative action and sustained commitment of key players across the health system; and 3) efforts to reduce substance use stigma within the health system must also acknowledge and address intersecting stigmas, including through initiatives not traditionally labelled as "anti-stigma interventions" (Public Health Agency of Canada, 2020).

More recently, Vancouver's council made history on November 25, 2020, whereby they unanimously supported a motion seeking to decriminalize possession of small amounts of illicit substances. This vote came after the BC Coroners Service reported 162 overdose deaths in the British Columbia in October, amounting to approximately five deaths per day (CBC News, 2020). While Vancouver does not have the power to decriminalize substance possessions, they will now seek an exemption from the federal Controlled Drugs and Substances Act. This is a big

step forward, moving away from criminalization efforts and to view people who use substances as a health issue, whereby they can feel comfortable to seek appropriate substance use services, as opposed to the fear of criminalization. This step forward also works to advance anti-stigmatization efforts around substance use. In fact, the motion states that it is a "necessary next step to reduce the stigma associated with substance use and encourage people at risk to access lifesaving harm reduction and treatment services" (Little, 2020).

As a result of the constantly changing landscape of substance use in Canada, many policies have been adopted using the four-pillar approach: prevention, harm reduction, treatment, and enforcement, as a guiding framework, such as within the current national Canadian Drugs and Substances Strategy (CDSS) (Government of Canada, 2017). The CDSS is the leading guidance document from which most Canadian substance-use related policies are shaped and derived from, and the tenants of the pillars have been proven effective when working with youth and adult populations (Government of Canada, 2017). While there is no specific youth strategy or policy that speaks to youth substance use issues, this national strategy endorses these pillars. The next section will take a closer look at the four-pillars and what each pillar aims to achieve when working towards addressing substance use issues.

Policy Pillars

For many years, community organizations, health professionals, service providers and users have called for a collaborative and standardized approach to address substance use issues. Considering the emerging and complex nature of substance use trends in Canada, approaches grounded in health principles had to be adopted. The four-pillar approach is recognized internationally- in

Europe and Australia- as an effective way to address the potential harms associated with substance use, as introduced in the Controlled Drugs and Substances Act (MacPherson and Rowley, 2014). This framework has been successfully used in cities such as Zurich and Frankfurt where there has been a dramatic reduction in the number of users using substances on the streets; a significant decline in overdose deaths; and a reduction in rates of HIV and Hepatitis (Knopt, 2019). The framework ensures a continuum of care for those suffering from substance misuse or substance use disorder, and for communities impacted by those people. It promotes realistic prevention and education programs; insists that treatment services for those who develop SUD be readily available and accessible; and helps reduce harms to individuals and communities as a result of substance misuse (Macpherson, 2001). While it moves away from the perceptions of criminalization and enforcement, whereby users were commonly stigmatized and characterized as criminals, it does recognize that enforcement and regulation is critical in reducing substance-related criminal activity and coordinating responses to the negative effects the illicit substance market may have on local communities (Macpherson, 2000). The implementation of this approach has evidently required a shift from traditional programming and policy responses to a public health approach, recognizing that services and the individuals within them are connected.

Prevention

Prevention programs are not simply a response to substance use; rather they are approaches that are ideally implemented prior to substance engagement (Abuse, 2016b). Prevention programs have the potential to do more than simply inform individuals about the problems associated with substance use. They are opportunities to raise awareness about why people may use substances, and what can be done to avoid misuse (MacPherson, 2000). Since there is an abundance of

research which indicates that the risk of individuals developing substance use problems can be influenced by certain life stages, such as adolescence, post high-school, it is critical to implement programs targeting the phases of life which pose the highest risk, such as adolescence.

Prevention efforts can be quite complex and diverse in nature; however, they typically consist of three main approaches: primary, secondary and tertiary prevention (Kisling and Das, 2019). Primary prevention strategies attempt to prevent substance use altogether or delay the onset of substance use. Secondary prevention is aimed at the early stages of substance misuse before serious problems are developed. Lastly, tertiary prevention interventions may focus on preventing serious harm to individuals who have become addicted to substances, or have developed substance use disorders (Kisling and Das, 2019). It is important to note that many interventions under the secondary or tertiary umbrella could also fall under harm reduction approaches. Prevention efforts are aimed at providing practical skills and knowledge, which build confidence and increase opportunities for making healthier decisions about their lives.

Treatment

Treatment includes a range of community-based medical and counselling interventions, outreach and bio-psychosocial programs that work with individuals experiencing difficulties with their substance use (Community Drug Strategy for Strathcona County, 2019). These services enable individuals to deal with their substance use, make healthier choices about their lives, and eventually resume their involvement in the community.

For youth who use substances, it is important to a have a variety of different treatment options available to them, to ensure ease of access and sustainability of use. Treatment programs for youth are fundamental (MacPherson, 2000). If they enter a program or service during this stage of their use, it can help them to manage their choices and decision-making in the future. However, as mentioned previously, it is critical that services and treatment options offer a range of options to deal with the multiple needs of each youth- whether that is housing, residential treatment or life-skills programs (MacPherson, 2000). It is also important to be mindful of administrative issues that many youth may be presented with when attempting to seek treatment, such as age cut-offs, geographical constraints, cost, or wait-lists. Youth oriented services must be accessible and provide a continuum of care when their treatment program is finished.

Harm Reduction

Harm reduction grew out of efforts in the 1980s to reduce the risks and spread of blood borne disease (e.g., HIV/AIDS, Hepatitis) among injection substance users. It is based on a value-neutral view of substance use and users, built on the premise that some users cannot or will not stop using substances, and interventions focused on abstinence will not be successful (Leslie et al., 2008). It is applied to both illicit and licit substances such as alcohol and tobacco. Harm reduction refers to interventions that seek to reduce the harms associated with substance use for individuals, families and communities. The philosophy of harm reduction is considered a pragmatic and evidence-based approach to substance use. Within this philosophy, the goal and intent is to meet an individual where they are at in terms of their substance use. As such, the focus is on the individual not the substance itself (Toronto Drug Strategy Advisory Committee, 2005).

Harm reduction for youth means meeting youth where they are at in their life and supporting them with their decision-making. As such, low-threshold programs are extremely vital for youth, whom can often times be the hardest to reach and have the greatest need. Low-threshold harm reduction programs are programs where abstinence is not a requirement for admittance (Strike, 2013). The primary purpose is to constantly work on and develop relationships with those on the borders of the health care system, and as such, focus on building relationships with often, marginalized populations. Low-threshold harm reduction programs have been extremely successful in substance strategies in Europe. In combination with a broad range of services, these programs function out of a variety of diverse facilities and provide a place for people to be off the street, away from the substance scene, and participate in positive activities (MacPherson, 2000). These programs are supportive in nature and provide critical guidance and information for those considering entering different treatment programs.

Enforcement

Lastly, the enforcement and regulation pillar works in coordination with the other pillars and refers to interventions that work towards strengthening community safety. This is done by responding to criminal activity and safety issues associated with the manufacturing, selling and trafficking of legal and illegal substances, and with use (MacPherson, 2000). There is evidently a clear relationship between crime and substance use. As such, enforcement comprises of the broader criminal justice system including police, courts, community-based initiatives, probation, parole, and crime prevention strategies (MacPherson, 2000).

In order to maintain public safety, the laws against the sale of illicit substances, and associated crimes must be enforced. Police play an important role under this pillar- working with community organizations and crime prevention groups to ensure that they are minimizing harmful effects of substance use or trafficking in communities (MacPherson, 2000). Some individuals with chronic and long-term substance use disorders may cause serious issues in their communities, including increasing crime and violence. Police are often the first point of contact for these individuals (MacPherson, 2000). They have the opportunity to provide a connection to an array of health and social support services in their communities; some even within the criminal justice system through the forms of diversion or drug courts. Through their daily contact with individuals who misuse substances, they have the ability to identify interventions that would not only benefit the community, but also the individual- balancing both needs.

While the Government of Canada hasn't formally adopted these four-pillars as 'legally binding', they refer to these principles in many documents that speak to the need to implement these pillars in all services that relate to substance use, as well as to inform various substance strategies. In chapter 7, I conduct a WPR analysis to examine the national CDSS to investigate how these pillars are framed within the strategy, how substance use is represented within the strategy and whether service provision related to substance use is reflective of these dominant approaches. As a result of the changing landscape of substance use among youth, as well as the evolving responses from the Government, many different programs have been developed to cater specifically to youth in Ontario. Recognizing the importance of these pillars, different interventions have been developed to support youth in different stages of their substance use. The next section will provide an overview of the youth service provider landscape in Ontario.

Youth Service Provision in Ontario

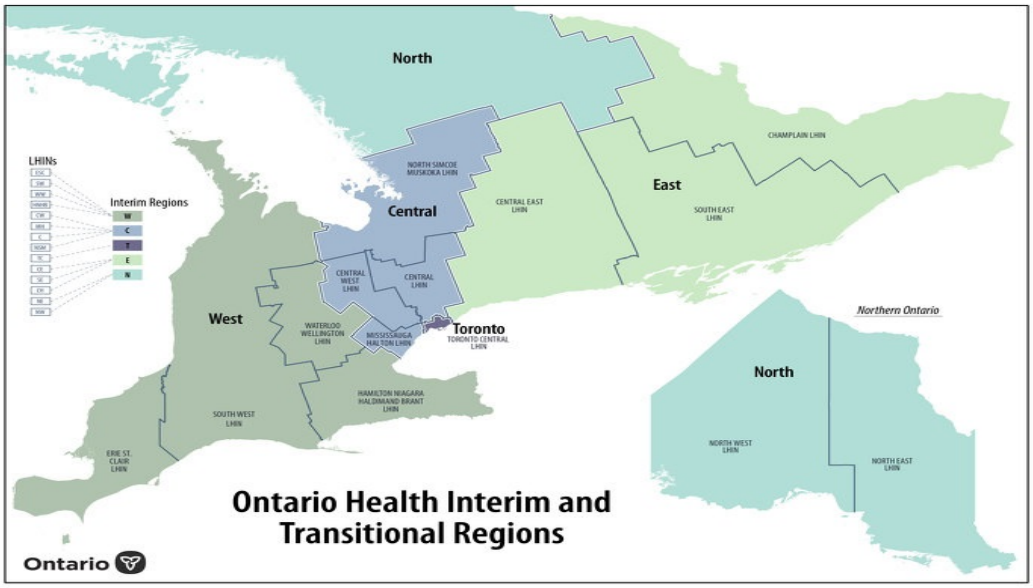
Historically, youth substance use services in Ontario have been modeled on adult services and offered to youth within adult settings, which is evidently inappropriate and non-effective. The needs of youth are very different from those of adults, and adult programs fail to provide developmentally-informed and effective youth-oriented services (Henderson, Chaim and Brownlie, 2000). The delivery and design of youth services should differ from adult programs in many ways. As such, the four-pillars approach to substance use has been increasingly adopted in the development of youth substance use services, recognizing their diverse needs as well as the importance of youth-oriented programs.

As a result of this increased recognition, over the years there have been several reports published in Ontario which have included a focus on youth substance use as a priority, highlighting the need for appropriate and youth-specific service provision. For instance, in 2014, the Ontario Government established *Ontario's Mental Health and Additions Leadership Advisory Council* who produced an annual report entitled: *Better Mental Health Means Better Health: Annual Report of Ontario's Mental Health and Addictions Leadership Advisory Council (*Mental Health and Addictions Leadership Council, 2016). This report focused on future priorities related to prevention, promotion and early intervention, youth addictions, and community mental health and addictions funding reform. The following year, the second annual report was published. One of the key recommendations outlined in this report called on the Ministry of Health and Long-Term Care to address the gaps in service capacity for youth substance use services (Mental Health and Addictions Leadership Council, 2016). Following the recommendations, in 2018 the Ontario Ministry of Health and Long-Term Care developed a *Substance Use Prevention and*

Harm Reduction Guideline to provide direction to the board of health on approaches and interventions in developing and implementing public health interventions for substance use prevention and harm reduction- essentially focusing on two of the four-pillars of the framework (Ministry of Health and Long-Term Care, 2018). While the guidelines were not 'youth-specific', they included the need to develop and implement a program of public health interventions using a health promotion approach to improve the health of school-aged children and youth. The abovementioned reports are a few examples of the increasing recognition and need to focus on substance use as a health issue and ensure that service provision continues to improve to rapidly respond to the evolving needs and challenges youth face. In order to understand service provision in Ontario, it is important to look at the service delivery model.

From 2007 to 2019, the organization and delivery of services in Ontario was based on a hierarchical model with Ontario's Ministry of Health and Long-Term Care (MOHLTC) at the top; not-for-profit, jurisdictionally-based crown agencies called Local Health Integration Networks (LHINs) in the middle (funded by the MOHLTC) which are responsible for the regional administration of public health care services in the province; followed by local public and private health service providers at the bottom (Ministry of Ontario, 2014). Previously, there were 14 LHINs in Ontario, each designated to a specific geographical area in the province, divided into the following regions: Erie St. Clair, South West, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West, Mississauga Halton, Toronto Central, Central, Central East, South East, Champlain, North Simcoe Muskoka, North East and North West. The LHINs were developed in 2007 to respond to a fragmented health care system and to support the implementation of services to meet localized needs in the respective areas (Ministry of Ontario,

2014). However, to build a more coordinated public health care system in Ontario, on December 2, 2019 the 14 LHINs were restructured into five interim geographical regions: West, Central, Toronto, East and North (Ministry of Health and Long Term Care, 2019). The following image provides an illustration of the amalgamation of the previous 14 LHINs into the five LHINs:



According to the Ministry of Health, this reorganization was operationally essential in establishing regional oversight between the existing LHINs, and to help ensure accountability and seamless service provision (Ministry of Health and Long Term Care, 2019). The five LHINs are controlled by five chief executive officers (i.e., transitional regional leads) who are overseeing the consolidation. As a result of this overhaul, the provincial government planned to collapse the administration of the LHINs, as well as five major health care agencies (i.e., Cancer Care, Health Quality, eHealth, Health Shared Services, and HealthForceOntario) into one overarching agency called 'Ontario Health' in April 2020 (Ministry of Health and Long Term Care, 2019). However, due to COVID-19, this transfer was postponed (D'Mello, 2020).

As part of the government's initiative to reconfigure and overhaul the Ontario health system, including the merging of the LHINs under Ontario Health, in December 2019, the Conservative Provincial Government made a huge stride in advancing mental health and addictions treatment in Ontario. A Bill to create a Centre of Excellence for Mental Health and Addictions was unanimously passed, whereby the provincial agency would oversee the new mental health and addictions strategy, support frontline service providers of related health services, and monitor how the services and system is working (CBC News, 2019). The significance of this unanimous decision indicated the support of all parties in recognizing the need to improve the mental health and addictions system in Ontario. The centre for excellence works with partners in the mental health and addictions sector, people with lived experience, and health care providers to guide the work, including critical representation from children, youth and adults (Ontario Health, 2020). This development is seen as a positive step forward under the addictions and mental health realm, as unlike other parts of the health system, mental health and addictions lacked a provincial coordinating body which oversaw quality and delivery of these services. While this amalgamation is progressive, it is unclear whether they will be following these guidelines or implementing these recommendations or focusing on youth specifically.

Additionally, in order to ensure that all Ontarians has access to information about services related to substance use, the Government of Ontario (through the Ministry of Health), funded ConnexOntario – an online service which provides free and confidential health services information for anyone who may be experiencing issues with substances, mental illness or gambling (ConnexOntario, 2020). ConnexOntario connects daily with service providers and other health professionals to gather current and accurate data about treatment, interventions,

support groups, and other health related services. ConnexOntario plays a significant role in contributing statistical data for the development of public policy and strategic planning around mental health and addictions treatment resources (ConnexOntario, 2020). The database provides information about where services are located, how to access them, and how long the wait to access the service may be. They have advanced search options, whereby individuals can search for services by location (LHIN, county, or municipality), by individual profile characteristics or preferences (language, gender or age), and/or by service name or type. As such, ConnexOntario is the most comprehensive database for addiction and mental health services in Ontario (ConnexOntario, 2020). In order to understand a general landscape of the substance use services offered in Ontario for youth, ***Appendix A*** provides a brief overview of the various services that are offered under the substance service umbrella in Ontario, as outlined by ConnexOntario.

Chapter 4: Theoretical and Methodological Considerations

Many unfair life circumstances related to the SDOH lead people to initiate substance use, which has the potential to lead to SUD, and as a result, a health equity lens that considers social injustice can help understand the drivers of use. The underpinnings behind health equity speak to the need to understand systemic issues, as well as other challenges and deterrents that people may face, which could contribute to an increased use of substances. Advancing the principles of health equity involves ensuring that everyone has a fair and equal opportunity to be as healthy as possible, regardless of their social position or other socially determined circumstances. Effective public health practices therefore aim towards decreasing health inequities to ensure that everyone can attain their full health potential without being disadvantaged. As such, the application of health equity as a guiding framework for my dissertation was extremely helpful. Furthermore, health equity and policy frameworks were used as a guide when collecting and interpreting the data from my study, and thus overlap with one another. The health equity and policy frameworks provided me with the structure and guidance on how to analyze and interpret my findings. For this reason, I have decided to present both the theoretical considerations as well as the methods employed, in a single chapter.

Health Equity and Policy Lens

Social, political, and economic determinants play a vital role in shaping the lives of youth. A health equity approach is directed at the societal causes of inequalities in health and the organization and delivery of health care and how public policy action can redress these issues. Therefore, my investigation, by seeking to identify gaps in services and access issues to service and treatment programs for youth who consume substances and come from a variety of

backgrounds – in terms of class, gender, ethnic/national origin and of their differential access to the social determinants of health – is critical to the field. As described by the World Health Organization: "In operational terms, pursuing equity in health means eliminating health disparities that are systematically associated with underlying social disadvantage or marginalization" (Ostlin et al., 2005, pg.948). An equitable health system needs to address specific needs for diversified youth, and the barriers that are systematically tied to the SDOH. It is imperative for services to be able to appropriately respond to vulnerable youth, who may have, or continue to experience challenging times, and ensure that service provision accessibility is not dependent on certain social or economic factors, such as socioeconomic status, family life, or neighborhood. When equal access to appropriate resources exist, communities are more likely to be happy, healthy and able to cope with life problems (Baciu et al., 2017). By using a health equity framework, I am able to look at the different challenges youth may face with regards to substance use, and ultimately, the services they may need. It is important to recognize the intersection of various determinants of health that may impact individuals to ensure that youth are appropriately supported. An equity lens is used to help understand that substance use and the related harms are increased by social conditions (Snyder et al., 2016). For instance, the harms associated with substance use are exacerbated when people face challenges related to poverty, housing or income, as described in chapter 2.

An analysis of the gaps and challenges that are related to social conditions, can help inform policy and program research and has the potential to advance social justice by improving equity in the distribution of services or by increasing youth's needs over decisions (Greer et al., 2016). The information gathered in this study can be used as a tool for health policy change, capacity

building, and equity by facilitating inclusion in decision-making in programs that involves service providers who directly work with youth users (Greer et al., 2016). Health inequity, as described, by the unfair and avoidable differences in health status, has been identified globally as a social justice issue. The root causes of health inequity can also be considered to play a role in the root causes of substance use. These causes can include poverty, gender and race inequity, and trauma (Baciu, 2017). A health equity framework can be used to advocate for policies and practices that acknowledge the complex circumstances that impact people's actions (Andermann, 2016). The development and implementation of policy has the ability to enhance or compromise health equity. Through the application of a health equity lens, I am able to help identify the key gaps in service provision, and where policy change can be most effective and result in the improvement of health inequities among youth who use substances. Policy-making plays a significant role in reducing health disparities and promoting health equity, and as a result a policy analysis of the current substance use strategy, CDSS, is critical.

Policy Analysis

Introduced in 1999, and modified in 2009, Carol Bacchi's 'What's the problem represented to be' (WPR) methodology is used to qualitatively analyze discourse. This approach is intended to facilitate critical interrogation of public policies. Bacchi developed this framework to analyze different aspects of policies, where she claimed that policy problems are socially constructed (Bacchi, 2009). She has argued that in order for real change to occur, the representation of policy 'problems' need to change, moving away from traditional policy paradigms that sees policy as simply a response to problems. Her framework begins at the premise that what the government proposes to do about a certain problem, reveals what they believe or articulate to be the problem

(Bacchi, 2009). Bacchi (1999) proposed that instead of evaluating policies strictly on their capacity to solve problems, it is fundamental to examine how these policies construct problems. Governments identify issues and draft corresponding policies or documents as a response to these problems. However, they draft these with intent, carefully choosing what will be included and ignored, and develop specific solutions or recommendations. Policies thus contain implicit representations of what is considered to be represented as the problem (Bacchi, 2012a).

The use of WPR is an emerging trend in policy analysis, where it is pivotal to challenge the assumption that problems exist independently of policymakers and government officials, and instead recognizing the key role governments play, where problems are not simply described but are indirectly produced (Bacchi, 2009). Bacchi argues that it is possible to use public policies as a starting point in understanding the problematizations of certain issues through which we are governed (Bacchi, 2012b). As such, it is policies which determine what gets done and what does not as it is framed and discussed at the government and policy level. With substance use issues rising and dominating the public health landscape, governments attempt to respond in different ways, as illustrated in chapter 3. As such, the application of a health equity lens in the WPR analysis provides a foundation to investigate the ways in health inequities among youth substance users can be reduced through understanding the problem representations of current policy responses and thus working towards improving policy-making.

However, advancing health equity through policy changes cannot be achieved without the application and understanding of the role the SDOH has on improving or perpetuating health inequities. As described earlier, the evolution of substance policy in Canada has moved towards

the understanding of substance use as a health and social issue, recognizing the role the social determinants of health play in use. The discussions around health have also evolved significantly since the 1980s, where definitions of health were very limited. The term health has evolved greatly in its definition, from a largely medicalized concept to now include other social and economic influences in its meaning, as health and illness have both social and biological components (Blaxter, 2010). This has also included the perceptions of substance use, and how it has shifted from a moral issue to a criminal issue and then to health issue, as previously discussed. It is thus important to look at the different ways in which the social determinants of health contribute to an individual's substance use patterns, including specific marginalized populations.

There is an abundance of research that looks at the roots of health disparities and how they lie within social and economic inequalities and exclusion (Lettner, 2008). More specifically, according to the *Conceptual Framework of the Determinants of Substance Misuse*, youth are affected at the individual, family, community and societal levels- all speaking to different social determinants of health, which was described in chapter 2 (Solar and Irwin, 2010). Giving greater attention to the social determinants of health can provide a perspective that recognizes the complex causes of substance use related health problems for youth. It could help paint a picture of how determinants may trigger the use of substances for youth. As a result, the concept of the SDOH was applied in my dissertation as a guiding framework to understand the equities and different factors that may impact individuals and thus their use. This approach provided me with the conceptual understanding of how multiple factors could impact the youth clients whom

attend or seek substance use services and be more conscious of the different barriers or challenges that some youth may distinctly face as they seek service provision.

Overall, an understanding of the root causes of health inequities within the health care system and in wider social contexts can help guide policy and interventions. This understanding can initiate the development of appropriate policy frameworks which establishes the role SDOH play in substance use, and work towards reducing health inequities that youth may experience when attempting to seek service provision. With the health equity and policy lens, and the SDOH explored, the next section looks at the specific methods which I employed to carry out my study. Recognizing the theoretical frameworks on how these approaches were applied is imperative in understanding why I engaged with the certain methodological approaches I describe below, and the foundation in which my data was collected, and findings were interpreted.

Reflexivity and Credibility: My position as a Researcher

Before I delve into the specifics of my methods, I lay out for the reader my credibility as a researcher and reflexivity with respect to this issue and my role as a researcher. Due to my central role in designing, implementing and analyzing the current study, to inform my credibility, it is important to position myself in the research (Patton, 1999). As a researcher at the largest addiction and mental health hospital in North America, Centre for Addiction and Mental Health (CAMH), I have over four years of experience working in research related to substance use, enhancing my credibility as a researcher. Through my academic background and professional experience, the research process – from start to finish- involved me consciously acknowledging preconceptions that my experience and knowledge contribute to the research study (Finlay,

2002). In fact, the process of reflexive analysis and consciousness began at the early stages of conceptualizing and identifying my research study. Due to my professional engagement at the hospital and as someone who is heavily immersed in research studies and literature related to substance use issues, I found myself gravitating to this specific topic. Further, through understanding the reality of substance use among youth via literature as well as lived experiences, the purpose and overarching aim of my study was conceptualized (Finlay, 2002). At the pre-research stage, I acknowledged my motivations, interests and assumptions that could be intertwined with the topic (Finlay, 2002). At the data collection stage, I carefully and distinctively relied on the surveys and key-informant interview transcriptions, as well as recognized how the data collected was informed by the methods applied and the researcher-participant relationship (Finlay, 2002). As discussions emerged with the participant, I constantly reflected on my own personal assumptions and preconceived ideas (Finlay, 2002). The reflexivity process was integral in the data analysis stage as it gave voice to the service providers, whereby I was able to identify themes that may have remained invisible to others (Finlay, 2002). Furthermore, to ensure the credibility of my findings at all stages of the research process, I made a special effort to remain aware of my own biases as a researcher (Finlay, 2002).

Methodological Approaches

In research, theory functions as a guide to the knowledge production process. In this section, I will present and outline the methodological approach of mixed methods, which I used to conduct my study. I will also discuss my engagement with the WPR analysis, and how it helped understand the reality of service provision versus how substance use problems are represented.

Once the methodological paradigm and approach have been discussed, I will discuss the details regarding the study design, including site description, recruitment and data collection processes.

Methodology

This study incorporated a mixed methods approach and engaged in an explanatory sequential design; whereby both quantitative and qualitative methods were integrated to inform one another. According to Creswell and Clark (2017), this method is a two-phased design, whereby quantitative data was collected first followed by qualitative data collection. The purpose of sequential explanatory design is to use the qualitative methodologies to further explain and add richness to the findings from the initial quantitative data collection phase (Creswell and Clark, 2017). Mixed methods research has been widely used within health care research. Quantitative and qualitative approaches integrate both epistemological and ontological assumptions and paradigms associated with both methods (Creswell and Wisdom, 2013). I believe that this design was most appropriate for my dissertation, as I collected both qualitative and quantitative data first by delivering the online survey to youth service providers in Ontario, followed by select key informant interviews that offered deeper insights and explanations into their survey responses, and identified missing gaps. Mixed methods research can be viewed as an approach which draws upon strengths and perspectives of each method, recognizing the importance of both the physical data, as well as reality and influence of human experience, whereby I could truly apply the health equity and SDOH lens. The primary design and data collection methodologies were self-administered online surveys, followed by a semi-structured qualitative interview with select key informants.

Mixed Methods

The concept of mixed methods was first introduced by Campbell and Fiske in 1959, where Campbell and Fiske used multiple methods to study psychological traits- although the methods used were different forms of quantitative methods (Creswell, 2013). Their work prompted other researchers to begin collecting multiple forms of data, such as combining observations and interviews with traditional surveys. In 1988, the concept of pragmatism was introduced to dismiss the notion that quantitative and qualitative paradigms are incompatible with one another (Howe, 1988). Then in 1989, Green et al., demonstrated the rationale for mixed methods by presenting typologies. Nurse (1991) then advocated for quantitative and qualitative approaches to be triangulated which will be discussed in greater detail shortly (Dumbili, 2014). Other scholars whom contributed to the development of the mixed-method approach are Bryman (1988) in the field of management, Creswell (1994) in the field of education, and Morgan (1998) who demonstrated the importance of triangulation in health research (Dumbili, 2014).

Early perceptions of combining methods were premised on the idea that all methods had their own biases and weaknesses and the collection of both qualitative and quantitative data would thus neutralize the weakness that emerged from each data technique. As such, triangulating data sources- a method of seeking convergence across qualitative and quantitative methods to increase confidence in findings- was born in 1978 (Dumbili, 2014). By the early 1990s, mixed methods approaches turned toward the systematic merging of both methods, and the idea of integrating mixed methods in different types of research designs emerged (Creswell, 2003). These designs were further developed for application in various countries and disciplines. From its establishment to present times, researchers that employ mixed methods research design have

applied different names, such as multitrait-multimethod (Campbell and Friske, 1959); triangulation (Jick, 1979); mixed-method (Green et al., 1989); mixed research (Johnson et al., 2007); and mixed methods research (Creswell, 2009) (Dumbili, 2014). While the name of the design may differ depending on which scholar one is guided by, at the core, mixed methods design remains the same. For the purpose of my dissertation, I will use the term mixed methods research, as identified by Creswell. According to Creswell and colleagues, mixed methods research is defined as "the collection or analysis of both quantitative and/or qualitative data in a single study in which the data are collected concurrently or sequentially, are given priority and involve the integration of the data at one or more stages in the process of research" (Creswell et al., pg. 212, 2003).

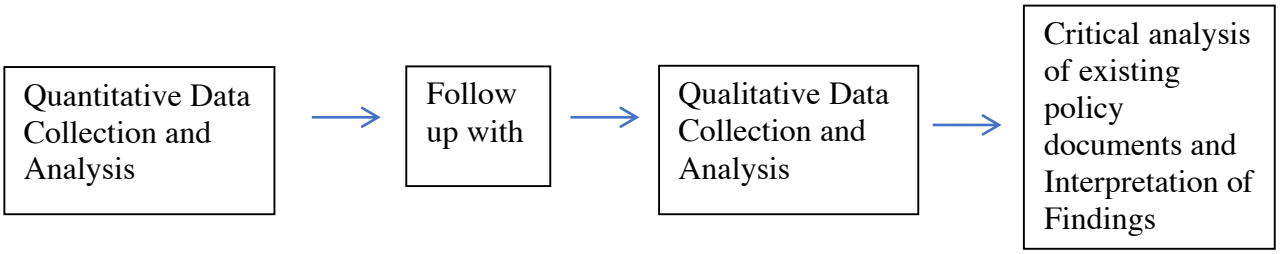
It has been argued that mixed methods research can be particularly useful in health care research as only a broader range of perspectives can do justice to understanding complex studies related to health (Pope, Ziebland and Mays, 2000). By combining both methods, researchers are able to more comprehensively address the research questions of interest (Tariq and Woodman, 2013). Qualitative and quantitative research designs have individual strengths and limitations (Creswell et al., 2003). As mentioned, qualitative data tends to be open-ended without predetermined responses, while quantitative data usually includes closed-ended responses such as surveys. However, with a mixed method study the strengths of both approaches compensate for any weaknesses by offering a new way to address these limitations (Ostlund et al., 2011). Mixed methods can provide more data for understanding the reason for an association, as well as, validate findings. Independently, quantitative and qualitative methods cater to different types of research questions. By combining the two designs a broader set of research questions can

provide answers about the strength of the relationships that exist and give meaning to a phenomenon (Creswell, 2003). Creswell and Plano Clark have argued:

> Mixed methods research is practical in the sense that the researcher is free to use all methods possible to address a research problem. It is also practical because individuals tend to solve problems using numbers and words, combine inductive and deductive thinking, and employ skills in observing people as well as recording behavior. (Creswell and Clark, 2011, pg. 13)

Although many designs exist within the field of mixed methods, three primary models are found in social sciences research: Convergent parallel mixed methods; exploratory sequential mixed methods; and explanatory sequential mixed methods (Creswell, 2013). For the purpose of my dissertation, I used the explanatory sequential mixed methods design.

Explanatory sequential mixed methods: This form of mixed methods design is when the researcher first conducts quantitative research, analyzes the results and then builds on the results to explain in more detail through the qualitative approach. It is considered sequential because the initial quantitative phase is followed by the qualitative phase. Typically, the participants in the qualitative stage, are those who participate in the quantitative study, usually in forms of volunteering to participate in the quantitative stage (Creswell, 2013). However, the sample sizes are unequal, as the qualitative study uses a smaller sample (Bian 2015). The ultimate goal of explanatory sequential design is that the follow-up qualitative data provided a better understanding of the research problem, than simply the first phase of data collection. The below diagram provides an illustration of the design (Creswell, 2013; Bian, 2015).



This approach enhanced the strength and rigor of the study by revealing any missing pieces that were not identified in the survey phase and helped to clarify any questions that may have arisen from the results. The rationale for this approach was to gather data in multiple forms, in order to gain a deeper picture of the issue at hand. While the quantitative survey data provided a general picture of the research problem, complimentary qualitative data had been used to refine and explain service provision and gaps for youth, identified through the surveys.

In addition to the abovementioned approaches, I also delved into an analysis entitled "What's the problem represented to be" (WPR) analysis to understand how substance use issues are represented by a dominant national substance use strategy (Bacchi, 2009). After conducting the mixed methods design, a more complete picture of the environment of substance use would be made clear. It allowed me to understand how a national policy represents substance use issues, and the approaches they propose to address them. It sheds light on the gaps between what was discussed by frontline service providers and what is directed by government and policy officials.

"What's the problem represented to be" Analysis Tool

The WPR approach is a tool intended to prompt critical investigation of public policies (Beasley and Bletsas, 2012). The WPR framework outlines four theories in which the tool is grounded upon: social construction theory, post-structuralism, feminist theories of the body and governmentality studies (Bletsas and Beasley, 2012). The 'WPR' acronym is intended to make it clear that the point of the analysis is to begin with suggested solutions to the problems, i.e. recommendations from policy or strategy documents, in order to appropriately critically examine their implicit problem representations (Bacchi, 2012a). When conducting a WPR analysis:

> Problems do not sit outside policy processes waiting to be solved. Instead, they are produced as problems of particular kinds *within* policies and policy proposals. That is, every policy proposal contains within it an implicit representation of what the problem is represented to be. (Bacchi, 2016, pg. 1)

The WPR approach uses interrelated questions that provide entry points for reflecting on and interrogating problem representations in governmental policies and practices. Bacchi's approach provides a conceptual 'checklist', which guides the analytical process, that consists of six questions to further probe how 'problems' are represented in policies (Beasley and Bletsas, 2012a):

1. What's the 'problem' represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underpin this representation of the 'problem'?
3. How has this representation of the 'problem come about'?
4. What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been (or could it be) questioned, disrupted and replaced?

While the abovementioned checklist is important in further breaking down the 'problem', many studies and researchers have only applied a few of these questions. As the questions are interrelated, there is evidently some repetition in the discovery, and therefore Bacchi has suggested that not every question needs to be addressed in every analysis, although it is useful to keep the full set of questions in mind (Bacchi, 2012b). As such, for the purpose of my dissertation, I used questions 1 and 2 to guide my research. My thesis only used these two

questions because my goal was to identify the problem representations in substance use policy. The other questions seek to interrogate and analyze the silences and effects of the problem representations, which is beyond the scope of this work. The first question assisted in clarifying the implicit problem representation within the substance use policy landscape. The second question aimed to encourage reflection on the underlying premises of how the 'problem' is represented. Bacchi points that the second questions should further ask the following questions: "What is assumed? What is taken for granted? What is not questioned?" (Beasley and Bletsas, 2012). What's interesting about this approach is that by looking at the policies or strategies put forward by the government, the critique lies in the ways in which these policies produce problems, with particular meanings which effect what gets done or not done (Bacchi, 2012a). Bacchi (2012a) states:

> What one proposes to do about something says a lot about what one views as problematic. The task in the WPR analysis is to read policies with an eye to discerning how the 'problem' is represented within them and to subject this problem representation to critical scrutiny. (Bacchi, 2012a, pg. 21)

As such, if policies are intended solutions to certain issues, then the WPR approach allows people to determine what is constituted as the 'problem'. For the purpose of my dissertation, the WPR analysis will critically examine the national Canadian Drugs and Substances Strategy (CDSS), the guiding national strategy in addressing and responding to substance use issues in Canada (Government of Canada, 2017).

Canadian Drugs and Substances Strategy (CDSS)

The Canadian Drugs and Substances Strategy uses the four-pillar strategy as its basis, and under the CDSS, the Public Health Agency of Canada (PHAC; the Federal governmental agency responsible for public health) has been working alongside the Federal Government to develop

policies and services to support people living with substance use issues or disorders (Government of Canada, 2017). The purpose of the strategy is to prevent and treat problematic substance use. This is done by focusing on both the enforcement of existing substance laws and the development of innovative approaches to harm reduction. The goal of the CDSS is to "protect the health and safety of all Canadians by minimizing harms from substance use for individuals, families and communities" (Government of Canada, 2017). The document uses the four essential pillars of: prevention, treatment, harm reduction, and enforcement as its guiding framework to support a comprehensive and multi-system approach to addressing substance related issues, and provides dozens of targets to indicate how the strategy will help achieve the abovementioned goals.

Since the CDSS is the leading guidance document from which most Canadian substance-use related policies are shaped and derived from, it is imperative to take a deeper look at how this document forms and contributes to the popular discourse, and to examine how it represents the 'problem' of substance use. In order to effectively undertake this and critique the CDSS using the WPR tool, I investigated not only how the 'problem' of substance use is framed within the document, but also looked at the proposed recommendations and identify and analyze the ways the 'problem' is implicitly represented within these solutions. Therefore, my analysis began from the CDSS' recommendations to see how the 'problem' was constituted within them. While I recognize there are many documents-federally, provincially, and locally- that speak to substance use, I decided to look at one document as a source for my investigation. Ideally, I was hoping to look at a Youth initiative or strategy that is designed specifically to target youth populations who use substances, however that is non-existent at both the national and provincial level. While

WPR is mostly utilized when examining policies, Bacchi agrees and supports the notion that even general government documents contain implicit problem representations, and as such, a specific policy is not necessarily needed to undergo such approach.

Now that I have presented the various methods used in my research, the next sections will provide a detailed overview of the study site, and understand the process in which a mixed methods approach was applied in data collection.

Study Design

Site Description and Recruitment

To support youth who face substance use issues there are 151 youth-oriented substance use services in Ontario. These programs range from counseling programs to treatment programs; are both publicly and privately funded and are dispersed geographically across Ontario. Most programs in Ontario are funded through the Ministry of Children and Youth Services (for young people up to age 16), and the Ministry of Health and Long-Term Care (for individuals older than 16). Navigating through the substance use service realm in Ontario can be challenging, especially for youth. To help assist with the identification of different programs and services, Ontario offers a comprehensive directory. ConnexOntario maintains a centralized, up-to-date and accurate database of detailed addiction services available in Ontario. They also have an online option for to filter through the services depending on what an individual is looking for, for instance to filter by demographic, location, wait-times, treatment type. This directory is very useful and informative in identifying the array of services available for youth.

As such, in order to understand the landscape of youth-oriented services in Ontario, I used the ConnexOntario database to recruit service providers working with youth from across Ontario.

ConnexOntario has information for over 5,000 government-funded services for problem gambling, addiction and mental health. In order to ensure that I was connecting with appropriate and relevant organizations that offer services for substance use for youth, I had to screen the services. Firstly, I used the filter service selection on the website to include only organizations that offered addiction services or support, thus excluding programs focused solely on mental health and problem gambling treatment services. I then further filtered the database to include only services catered to youth. The list of eligible services was then organized based on geographical location and organized into an excel sheet, which included the program name, the contact information- usually a phone number to the main line- and the location of the service. The final dataset for eligible youth-oriented substance user service organizations in Ontario included 151 organizations**.** ***See Appendix B.***

In terms of participants, I was only interested in connecting with service providers who delivered- or was aware of- frontline substance use treatments, interventions, and programming to youth (e.g., health care providers and/or administrators), while those who provided only mental health support/treatment were to be excluded during this recruitment phase. In the initial step of engagement, in October 2019, I contacted via telephone, each service provider listed on the service provider database spreadsheet. This initial contact allowed me to confirm the types of services the organization provided (i.e., ensuring that youth-oriented services are provided), in addition to explaining the project. During the process of initial engagement, I did not have to exclude any services, as all services I connected with provided some sort of youth substance service or support. I was interested in speaking to someone from their respective organization who had frontline or detailed understanding of the client's substance use and issues. Staff

members at the organizations then helped to identify the correct person to send the survey link to, based on participant eligibility criteria. They either directed me to their telephone line or gave me their phone number/email address for me to contact them directly.

For the most part, I was provided with the identified contacts name as well as their phone number, to ensure that I was able to directly reach them at some point. I used the excel sheet to track whom I connected with, on what date, the contact information for the individual identified, especially their email address, and whether they indicated their interest in participating. For some organizations, there was one point of contact for different programs offered within their organization, to which I was able to collapse the different services into one. For those that were not available to speak, I either left a voicemail with my contact information for them to call me back, or when a voicemail option was not available, I attempted to call another day until I got a hold of someone. While some organizations expressed interest right away and it was easy to connect with and identify a point-of contact, there were other organizations which were extremely difficult to find the correct point-of-contact or gauge interest. There were 13 services whom I was never successful in contacting, and 30 services whom I initially was able to speak to someone, however they never called me back, or responded to my email.

Survey Tool

The first step of the study was to ensure I developed a survey tool that would allow me to gather the data I needed to answer my research questions and the goals of my study. The survey itself was designed as a mixed methods tool, gathering both quantitative and qualitative data. I also wanted to ensure that the survey was not too long and would on average take about 15-20

minutes to complete. In order to do this, I had to ensure that I was asking clear and concise questions, and that I designed the survey in a manner that allowed for participants to answer the questions in not only a timely manner, but by also providing useful information.

I chose the online platform called *Research Electronic Data Capture* (REDCap) to host my survey. REDCap is a secure web application for building and managing online surveys and databases. REDCap is a user-friendly web platform that provides a powerful tool for creating and managing online surveys. It has many features that has made the data collection and extraction phases relatively seamless for my study. It offers a stream-lined process for rapidly building a survey and offers multiple survey development tools such as branching and skip logics. It was also extremely helpful in tracking responses and sending out scheduled follow-up emails. Another major reason I decided to use this program is because it exported data to common statistical packages such as SAS, the program to which I was using for my study.

Before asking specific service and substance-related questions, I asked background questions to get a better understanding of whom is responding to my survey in terms of roles, from which organization they were responding from, as well as identifying geographical location to look at representation of responses. As such, the first three questions were textbox fields, asking participants to specify their organization name, the specific program name they were responding on behalf of, and their role in the organization. These fields were mandatory and required a participant to respond. I was aware that many of the organizations that I would reach out to, would be very large and host many different programs and services for youth. As such, I wanted to ensure the participants were responding on behalf of their specific youth program, and not the

organization itself. Since I was also interested in getting frontline service providers perspectives, the question asking their role in the organization would allow me to see the representation across different service providers that work with youth. Since this is a province-wide study, I also wanted to guarantee that I got representation from across the Ontario LHINs.

To help identify geographical regions, I concluded that the best way to look at the representation, would be to divide the province based on the Local Health Integration Networks (LHINs). I decided to use this method to organize my data because I wanted to ensure I was collecting consistent information, recognizing that participants may distinguish their geographical parameters differently. As discussed earlier, LHINs are crown agencies established by the Government of Ontario to plan, coordinate, integrate and fund health services at the local level, including addiction services. As such, the fourth question asked participants, using a check-box option, to select which region(s) their organization served based off of the LHIN distribution. When the survey was developed in September 2019, Ontario was still organized into 14 LHINs, as described in chapter 3: Erie St. Clair, South West, Waterloo Wellington, Hamilton Niagara Haldimand Brant, Central West, Mississauga Halton, Toronto Central, Central, Central East, South East, Champlain, North Simcoe Muskoka, North East, and North West. I also included an option to check 'Province-wide (my organization serves youth from across Ontario)'. Participants were asked to 'select all that apply', in the event that their service operated in different LHINs. I included an attachment of the Ontario LHIN map to ensure participants responded accurately, and there was no confusion in identifying regional distribution.

I was then interested in seeing which services each organization/program provided. This would allow me to get a general sense of the youth service provision landscape, what is being offered, and what the gaps are in terms of service provision in Ontario. I again decided to use a check-box option, whereby the question would ask participants to select all the services that their organization provided from a list. I developed the list based on researching different programs from across Canada to see what services are being offered within the substance use and addiction realm. I also chose not to only include youth-specific services, rather any service that was identified as offered, to broaden the scope of services. As such, the services included on the list were common substance use and addiction services, based on both research as well as my experience working in the substance use field. The final list included: individual counselling, family counselling, group counselling, detoxification/withdrawal management, in-patient/residential treatment, out-patient/community treatment, case management, relapse prevention (CBT, healthy coping skills), recovery and/or support services (continuing care, self-help groups, peer support), shelter/temporary housing (short-term), transitional housing (medium-term), educational services (training, employment), harm-reduction services (needle exchange, naloxone provision), outreach, and 'other'. I chose to include the 'other' option recognizing that the list of services was not exhaustive. If a participant selected the 'other' field, there was a branch logic where they were asked to specify which service they were referring to using a textbox field.

Since there is no consistency in the definition of youth, I was interested in exploring how youth is defined, by looking at the age range in terms of eligibility and cut-offs from each service, as an average age range provided by participants would provide me with some insight. As a result, the

sixth question asked participants to identify the age range for their service, using a textbox field. I included an example age range: e.g. 12-20 to give respondents an example of how I expected them to answer the question.

I was then interested in looking at how many youths these organizations served on average in a given month. This would give me information regarding service capacity, youth access, and demand of services. As such, the seventh question asked participants to identify approximately how many youth access their organization services in a given month. I provided check-fields, to allow participants to select a number range: less than 50; 51-100; 101-150; 151-200; 201-250; 251-300; and more than 301.

The next set of questions looked at substances specifically. One of my specific research questions was to determine the most frequently used substances among youth in Ontario. To answer, the eighth question asked participants to rank the top three most frequently used/reported substances among youth who access their services, with '1' being the most frequently used/reported, '2' being the second most frequently used/reported and '3' being the third most frequently used/reported, by using a matrix grid. I listed the major and commonly used/known illicit and non-illicit substances: opioids, alcohol, tobacco, cannabis, methamphetamine, cocaine, other stimulants (ecstasy/MDMA, Adderall, ephedrine, amphetamines etc.), and hallucinogens (LSD, magic, mushrooms, DMT, PCP, Ketamine etc.). I also included an 'other' option, recognizing that my list again was not exhaustive. If a participant selected 'other', a branch logic was set up where participants were asked to specify which substance they were referring to in a textbox. Participants were only allowed to select one substance for each rank, and they were not

allowed to select the same substance in a different category. For example, if they selected opioids as the first most used/reported substance, then they were not allowed to select opioids as the 2nd or 3rd.

Since the intent of my study was to also identify effective services that would be helpful in supporting youth with their substance use, it was important for me to explore which interventions service providers found as the most effective in addressing substance-related issues. As a follow-up to the above question, which asked them to rank the frequently used/reported substances, the survey was developed with a branch logic tool that prompted them to answer the ninth question, which asked which intervention(s) would be most effective in addressing issues related to those substances they selected. The specific question asked participants: "for the substance which you identified as #1 (the most frequently used/reported), please identify which intervention (s) would be the most effective in addressing issues related to that substance (select all that apply)". A checkbox field was displayed, where they selected all the intervention(s) they find effective in addressing issues to the substances they listed as the first, second, and third most reported.

The list of interventions was populated based on research of different intervention approaches used within the substance use realm in Canada, again, not youth-specific. The interventions listed here used the same service list that was used in question 5. The list included: harm reduction interventions (needle exchange, naloxone provision); policy interventions (legislative/regulatory change); prevention interventions (early intervention, education, focus on high-risk groups); pharmacological interventions (opioid agonist treatment); non-pharmacological interventions (CBT, motivational interviewing); system improvement (integration and availability of wrap-

around services, standardized data/monitoring programs); knowledge exchange activities/products (pamphlets, infographics, webinars, conferences) and 'other'. I chose to include the 'other' option recognizing that the list of intervention options was not exhaustive, and I welcomed alternative intervention responses that they deemed effective. If a participant selected the 'other' field, there was a branch logic where they were asked to specify which intervention they were referring to, using a text field box.

Once they had selected effective interventions in relation to the top 3 frequently used substance they identified, the tenth question focused on looking at gaps in effective services. I was interested in understanding which services youth-oriented programs would find useful and effective in working with their youth, that they did not currently offer. For this question, I used a checkbox option, where I used the same list of services that I itemized in question five and nine. I asked participants to identify which of the following services their organization currently does not offer, but would be useful to offer for youth in the future. They were given a select all that apply option, and an 'other' option. If a participant selected 'other', there was a branch logic where they were asked to specify which service they were referring to using a text field box.

The eleventh question focused on addressing one of my specific research questions, looking at the specific challenges in accessing youth services in Ontario. This question used a checkbox option, where they were asked to select all that applied from a list of potential challenges. I developed this list based on research of challenges and barriers identified in accessing services across Canada. The list included: geographically inaccessible; lack of resources (staff, equipment); lack of programs; lengthy wait times; fear of stigma or discrimination; restrictions

on eligibility for programs/services; none or not applicable; and other. I decided to include no or non-applicable as an option recognizing that some services may not feel that there are any challenges or barriers in accessing youth-specific services. I also included the 'other' option, acknowledging that the list of challenges is not exhaustive, and there may be other barriers that I may not be aware of. If they selected the 'other' option, there was a branch logic where they were asked to specify what challenge or barrier they were specifically referring to, using a textbox field.

To wrap up the survey, the last two questions focused on identifying research priorities from the perspective of frontline workers in youth services. The twelfth question asked respondents to identify the top three substances they believed research should focus on/prioritize over the next 3 to 5 years. Using a similar approach as question (8), I used a matrix/grid to allow participants to select their first, second and third priority substance. I used the same list of substances as I did in question 8, including the 'other' option, acknowledging that another substance not listed could be considered a research priority. The ranking order again was consistent with question 8, where 1 was a substance they identified should be most prioritized, 2 being the substance second most prioritized and 3 being the substance third most prioritized. Participants were only allowed to select one substance for each rank, and they were not allowed to select the same substance in a different category. For example, if they selected opioids as their first priority substance for research, then they were not allowed to select opioids as the 2nd or 3rd priority as well. The final question asked participants to specify which types of research they would like to see and why they believed these areas of research would be beneficial. For this question, I generated a textbox, allowing them to write whatever they felt would be useful and effective, and gave some

examples in the question: clinical research, pilot projects, academic publications, or best-practice guidelines.

I concluded the survey by including a textbox, providing participants with an opportunity to share any additional information or comments that they felt was relevant. This was the only prompt in the survey that was not a required field. Since I was also using the survey to gauge interest in participation in the key informant interview phase, I included a question whereby I asked participants if they were willing to participate in a follow-up interview to further discuss these issues. There was also a note outlining that their information would be kept confidential and anonymous, and that they will be compensated for their time and participation. They had the option to select 'yes' or 'no'. If they selected 'no', the survey was completed and they were directed to a landing page which thanked them for their time and participation. If they selected 'yes', a branch logic was set up where they were asked to provide their preferred email address in order to be contacted. ***See Appendix C for full survey.***

Study Inclusion/Exclusion Criteria

Inclusion: The focus of this project was an organization-level survey of service providers in Ontario that provided substance use treatment, support or interventions to youth. The online survey instructions requested that the questionnaire be completed by a frontline worker, or someone from the organization, whom understood and/or was responsible for the substance user and addiction services provided in the organization, and must be familiar with the substance use patterns and challenges their clientele faced. Participants had to understand and be fluent in

English and have access to a computer in order to participate in the study.

Exclusion: Service providers that only provided mental health treatment or services, or problem gambling were excluded from the survey. Service providers that did not provide services to youth were excluded. Service providers who did not provide frontline substance use services and/or have knowledge of service administration, challenges, patterns of youth in the organization were excluded. Service providers who were not fluent in English were excluded from the study.

Data Collection

The study protocol and all procedures were approved by the Centre for Addiction and Mental Health Research Ethics Board (REB# 063/2019-02) and from York University Ethics Review Board (STU 2020-010). Once a full list of the eligible service providers had been confirmed, and the name and email address of an eligible individual from each organization had been identified, an invitation to participate and link to the online survey was sent via REDCap. The email sent to thanked them for their interest, provided context about the study and a link that directed the participant to a landing page that outlined the study procedures and objectives, in addition to the informed consent details. This page informed participants that by clicking the button to proceed to the survey they are consenting to participate. On the informed consent form, I estimated that the length of time required for survey completion was approximately 15-20 minutes; however, response times could vary, depending on the nature and extent of services delivered. Participants were informed that they had the option to save their responses and complete the remainder of the survey at another time. I included a setting in REDCap to allow for follow-up emails to be sent

in the case that surveys were incomplete or not opened. Two weeks after the survey launch, all non- (or incomplete) respondents were sent a reminder email. If a response to the survey was not received at 5 weeks' post-launch, a final reminder was sent via REDCap.

Data Collection Summary

Data collection for the first phase of the project was completed between October 2019-December 2019. As of December, 28th 2019, I had 66 surveys opened on REDCap, with 12 of them being incomplete. Since it had passed the 5-week post-launch, no final reminders were sent to those that partially completed the survey.

Key informant Interview Guide Development

The second phase of data collection was the qualitative component of the key informant interviews. The use of qualitative research methodology helped explore why or how a phenomenon occurred, supported the development of a theory, or described individual experiences. Key informants are much like community advisors with whom one cultivates a relationship to get a better understanding on what is occurring in a particular local setting (Nichter et al., 2004).

As such, the key informant interview guide was developed following analyses of the survey data. I chose to develop the questions based on the survey results because it allowed me to ask more directed and targeted questions concerning the issues raised by service providers, and gain clarity around the results of the survey. This flexibility was extremely beneficial because the survey

data resulted in some unanswered questions that I wanted clarity around, and was interested in exploring some of the themes that emerged.

Based on the results of the survey data, I was particularly intrigued by the fact that cannabis emerged as not only the number 1 substance being reported by service providers, but also the number 1 priority area for research, followed by alcohol respectively. I wanted to know whether these substances, mainly cannabis, were considered problematic substances, or just substances that were reportedly being used by youth, and why service providers felt that these substances are so frequently used among this population. I was also interested in understanding whether these high rates were associated with the legalization of cannabis, or if services that work with youth didn't necessarily see an upward trend. I wanted to also explore what frontline providers felt to be effective services and interventions given their experience with youth, and how/where they would like to see these services implemented. The data also left me wondering whether youth whom were accessing the services were coming independently- because they perceived themselves to have a substance use issue- or rather it is a family member, court order, school counselor etc. which brought them to the service. I was also interested in hearing their perspectives around access issues related to stigma, and effective approaches in addressing stigma-related concerns. Since detoxification was identified as a useful service for youth, but a service that was currently not offered, I was interested in understanding why that was the case, and which substances they were specifically referring to when it came to detoxification. As such, I developed 9 open-ended questions, with subsequent probes where appropriate for my key informant guide. ***See Appendix D for key informant guide.***

The key informant interviews were designed as semi-structured individual interviews. Semi-structured interviews are commonly used in qualitative research and are the most frequent qualitative data source in health services research (DeKonchkheere and Vaughn, 2018). This method involves a one-on-one conversation between the researcher and the participant, guided by a semi-structured (flexible) interview guide and related probes. This style of data collection is powerful as it allows for rapport to be built between the researcher and participant, and encourages a deeper exploration of the experiences, thoughts and beliefs expressed by participants. At this phase of data collection, a relationship had already been built between myself and the individual, through the initial engagement during the first phase of data collection. I intended on using this data collection method to complement the survey data, as the qualitative data will allow me to more deeply understand participants' perspectives and insights regarding gaps and challenges in youth-oriented substance use services in Ontario, in addition to priorities for future research. This follows the approach of my research method technique of the explanatory research design.

Phase II: Data Collection

Once I finalized my key informant guide, the second phase of recruitment and data collection ran from February 7, 2020 through February 28, 2020. I identified all the individuals whom responded 'yes' to participate in a key informant interview from the survey, and compiled their contact information into a password-protected excel spreadsheet. Of all the people that participated in the survey, 26 individuals were interested in being a key informant. While I was interested in conducting 15-20 key informant interviews, as decided in my proposal, I suspected that all individuals would not be interested in participating, or I may run into issues

contacting/reaching them again. As such, I decided to contact all individuals via email and ask them if they were still interested in participating. On February 7th, 2020, I emailed all 26 individuals who expressed their interest in participating. After I sent out my initial email gauging their interest, if I didn't hear back from them, I sent out a follow-up email on February 21st, 2020. On February 28th, 2020, I sent one last follow-up email. In total, of all the people I contacted, 16 individuals positively responded indicating their interest. I began scheduling both in-person and over-the-phone interviews from February 18th, 2020 to February 28th 2020. Key informants received $30 honoraria for their time and participation from 3 stores of their choice: Tim Hortons, Amazon or Walmart. The geographical breakdown of where/region key informants participated from will be discussed in the findings chapter.

All interviews were approximately 20 to 40 minutes in length, confidential, and conducted by myself. Most of the interviews were conducted over the telephone (n=10) to allow service providers located across the province to participate, and to ensure I was able to complete my key informant interviews in a timely manner. Local service providers had the option to complete a face-to-face interview, if preferred, and a total of six face-to-face interviews were conducted. For the face-to-face interviews (n=6), interviews were conducted at their office. All interviews were audio-recorded and transcribed.

Informed Consent

The purpose of the study, procedures, time commitment, potential risks and benefits, and confidentiality were all explained to participants via consent forms. For those interviews conducted over the phone, I sent a copy of the informed consent form via email in advance of the

interview. I would then go over the informed consent form with the participant over the phone, answer any questions they may have, and request for them to verbal consent to participate in the interview. Once they consented, I proceeded with the interview and turned the audio-recorder on. For the in-person interviews, I brought a copy of the informed consent form, and went over it with the participant in person. Once they signed the form, I proceeded with the interview. In both instances, it was made clear that prospective participants could terminate their participation in the interview at any time, including the dismissal of any data that may have provided. The informed consent sheets also outlined what would happen to the data once the study was completed, as well as how the data would be used as part of a dissertation, and including its potential in any reports or publications. All interviews were conducted in English.

Data Analysis

In January 2020, I exported all the data from the surveys into an excel database and subsequently uploaded into a statistical software program called Statistical Analysis System (SAS), a data management program. I excluded the 12 incomplete surveys, giving me a total of 54 completed surveys to analyze, resulting in data collection from 36% of services contacted. I then conducted simple frequency and cross-tabulations to explore the responses, and graphs were created for data visualization, when appropriate.

The key informant interview transcripts were reviewed individually by me. All interview transcripts underwent an inductive thematic analysis using NVivo, a qualitative data analysis computer software, whereby key themes were identified based on the research questions and subsequently organized into different categories (Braun and Clarke, 2006). Thematic analysis is

commonly used in qualitative research to identify, analyze and report themes that emerge within the data (Braun and Clarke, 2006). I developed an initial code list based on themes that emerged from the interviews, and additional codes were added based on emerging themes that arose during the analysis phase. A theme was considered as something important that emerged from the data in relation to the research question and offered some form of patterned response or meaning (Braun and Clarke, 2006). Themes were then included in final analyses when they were introduced or discussed by numerous participants, and from these, select illustrative quotes were chosen to narratively represent the themes, as such applying an inductive approach, whereby thematic analysis was data-driven (Braun and Clark, 2006).

Credibility of Findings

To enhance the credibility of my findings, I engaged in a variety of different methods of analysis, including discussions with my supervisors who, upon reading selected portions of transcripts, helped me identify themes and interpret the findings. I also applied methodological and data triangulation, such that the validity of my findings was confirmed through the statistical output of the survey findings into SAS as well as the concise reporting of key-informant interviews transcripts which were transcribed verbatim. As described by Patton (1999), the methodical process of both analyzing and reporting the data allows others to judge the quality of the findings (Patton, 1999). Furthermore, the process of triangulation informed my choice of a combination of qualitative and quantitative methods that I selected to answer different kinds of questions, both of which I drew from to inform my investigation (Patton, 1999).

In the next chapters, I present the findings from both the survey and key informant interviews.

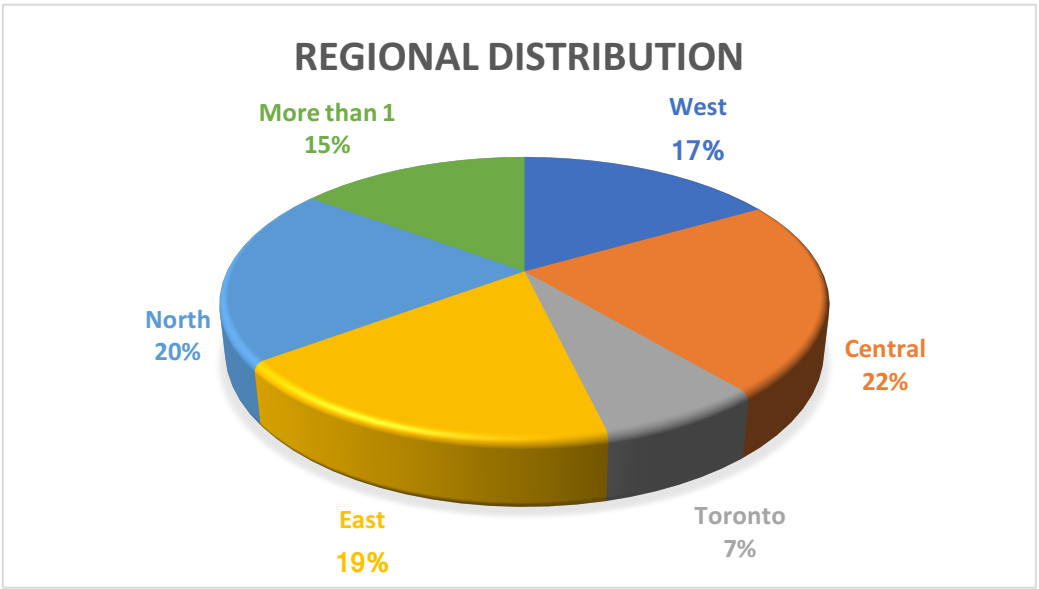
Chapter 5: Survey Findings

Out of the 151 organizations I contacted from the ConnexOntario dataset, there were a total of n=54 service providers who completed the online survey component of my study.

Geographical Representation

To understand the geographical representation of the services, I asked participants to identify which region their organization served. The survey provided checkbox options, whereby participants could select different Local Health Integration Networks (LHINs), if their services spread through different LHINs/regions. As explained in the previous chapter, I reorganized the LHIN categories for organization purposes to reflect the new reorganization of the LHINs– West, Central, Toronto, East, North, and serves more than 1 LHIN. Using SAS, I re-coded the LHINs to reflect the changes made to the categorization of the LHIN, and collapsed the original 14 LHINS into 6. After completing the coding and running the data, the geographical distribution of the services whom participated in the survey were as follows:

Figure 1:

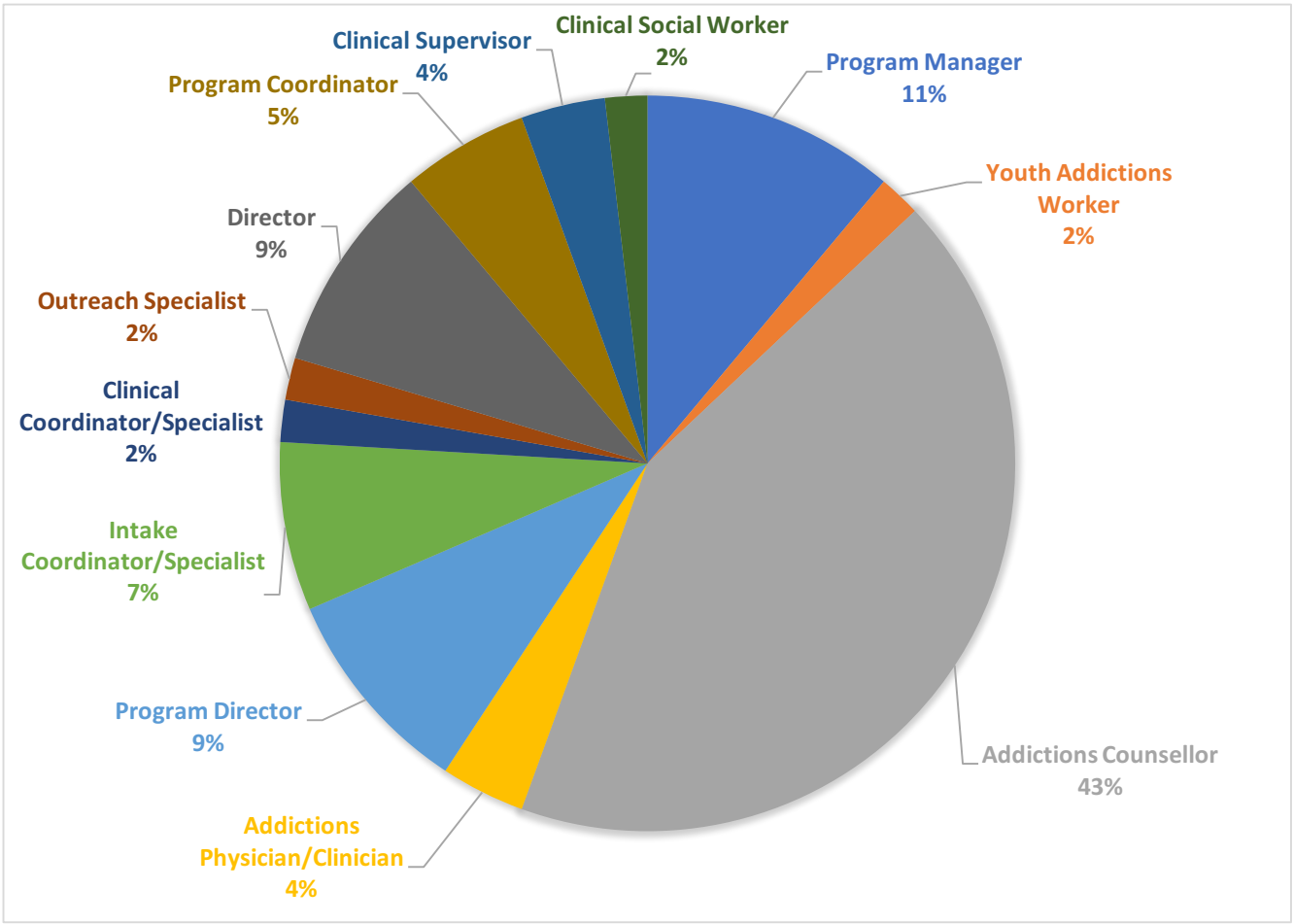


Most respondents came from the Central (n=22) and Northern (n=11) LHINs, respectively, however, all regions were represented in the data.

Participant Roles

In terms of the participants, I was interested in hearing from those that worked on the frontlines directly with youth, or whom were responsible for overseeing the youth program(s) in their respective organization. Using a text box field, I asked participants to identify their role in their organization. The following is the breakdown of participant's roles:

Figure 2:

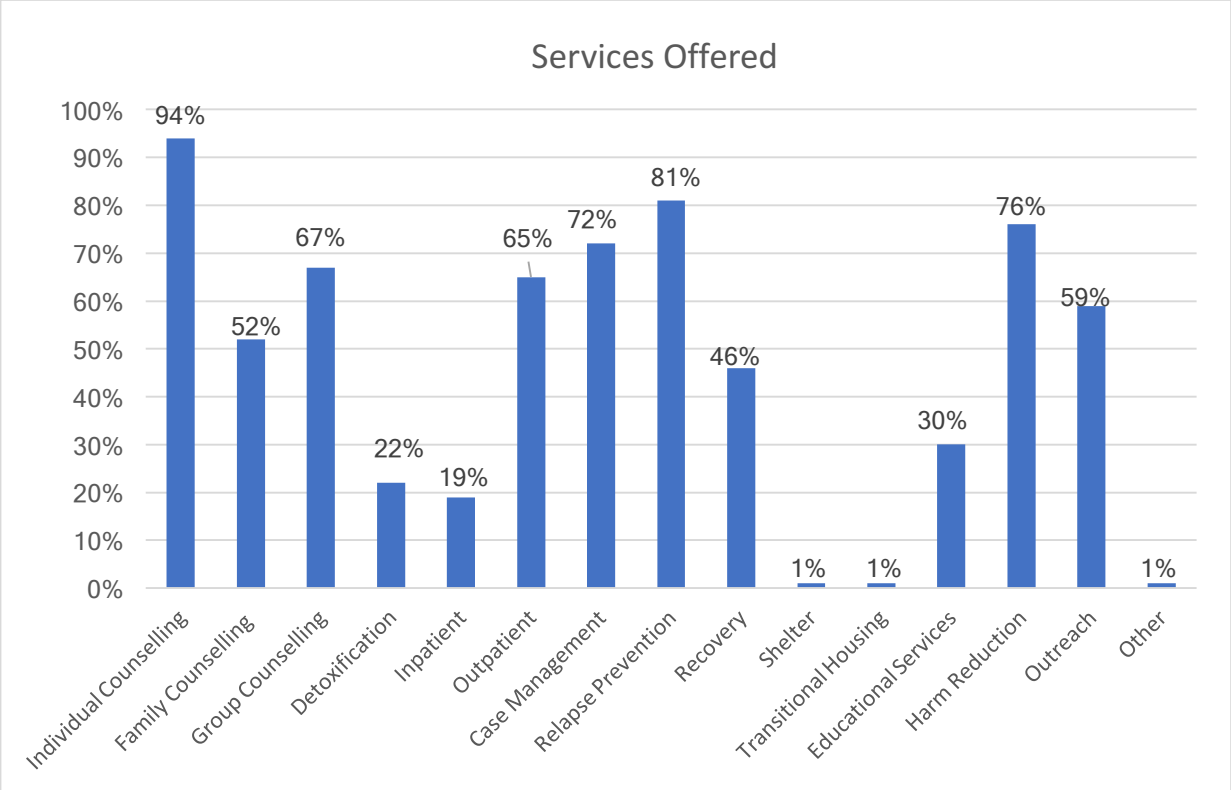


The majority of respondents were addictions counselors (n=23), followed by program managers (n=6) and program directors (n=5).

Services Offered

The next question asked participants to identify all the services their organization/program offered, from a list of services, by checking all the services that they offered. If there was a service that was not listed, participants had the opportunity to select 'other' and list the service in a text box field. I was interested in understanding the breadth of services being offered across the province. The table below identifies the percentage of organizations offering each service:

Figure 3:

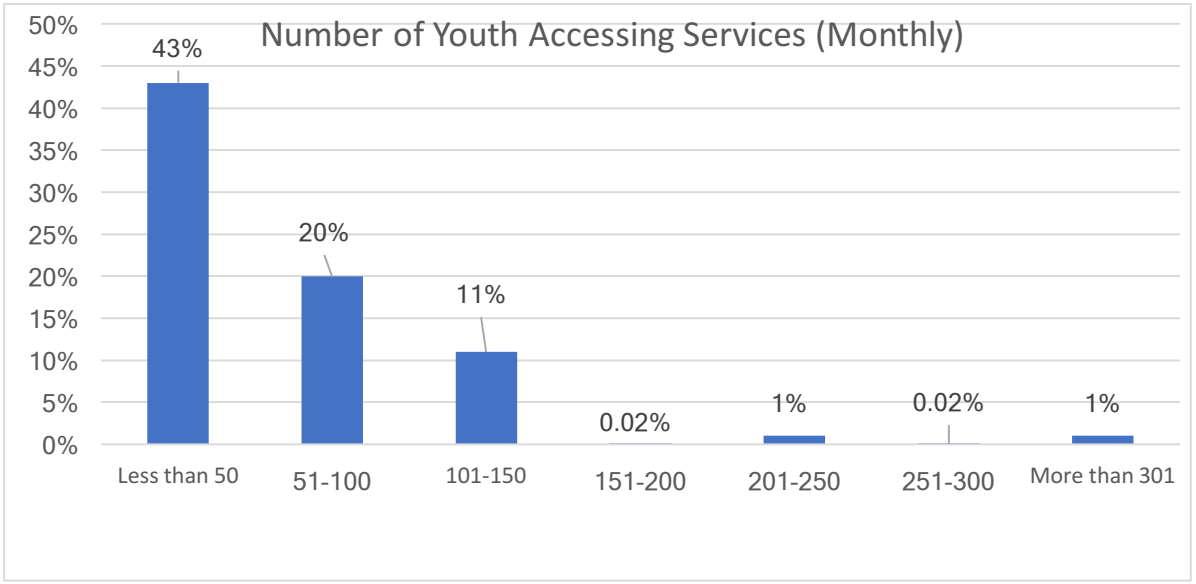


Based on the results, individual counseling (94%; n=51), relapse prevention (81%; n=44) and harm reduction (76%; n=41) were the top 3 services offered among all the organizations whom participated, respectively. However, on the flip side, only 1% (n=4) of organizations offered transitional housing and shelters for youth.

Number of Youth Organizations Served in a Given Month

The next question asked participants to identify approximately how many youth access their services in a given month, as I was interested in understanding service capacity. The response options were check boxes to select the appropriate number range, which were broken down into the following ranges: less than 50, 51-100, 101-150, 151-200, 201-250, 251-300, and more than 301. Since two participants selected more than one category, I had to remove the duplicated response from data analysis, leaving n=52 respondents. After importing the data into SAS, the results for service capacity is illustrated below:

Figure 4:

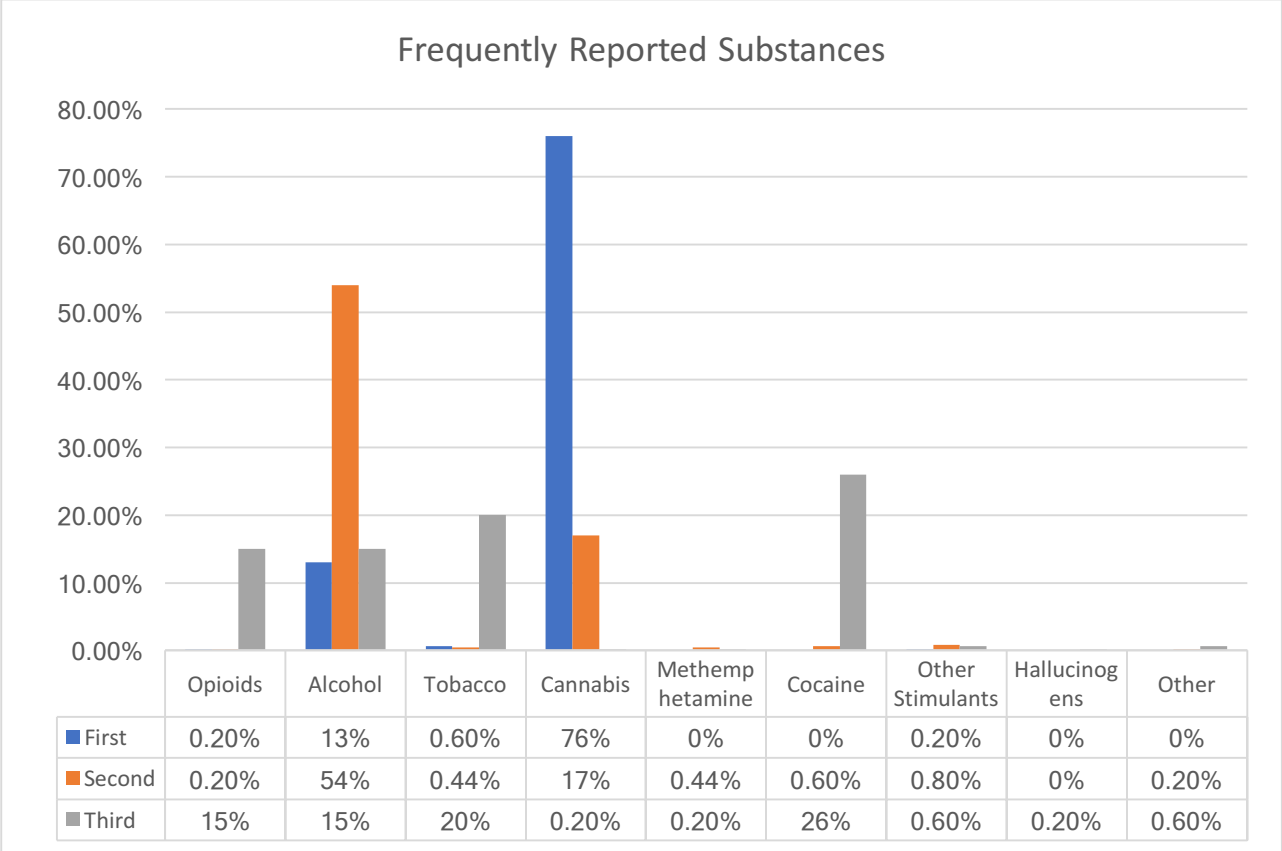


Based on the responses, 74% (n=40) of the participants identified that they serve approximately between 1-150 youth on a given month. With the majority of services, 43% (n=23) serving less than 50 youth on average in a given month.

Frequently Reported Substances

The fifth question on the survey asked participants to identify the top three most frequently reported/used substances among youth whom access their services. The breakdown of responses and substances identified are illustrated in the graph below:

Figure 5:



	Opioids	Alcohol	Tobacco	Cannabis	Methemphetamine	Cocaine	Other Stimulants	Hallucinogens	Other
First	0.20%	13%	0.60%	76%	0%	0%	0.20%	0%	0%
Second	0.20%	54%	0.44%	17%	0.44%	0.60%	0.80%	0%	0.20%
Third	15%	15%	20%	0.20%	0.20%	26%	0.60%	0.20%	0.60%

Based on the responses, 76% (n= 41) of respondents selected cannabis as the number one frequently reported substance among youth, 54% (n=29) of service providers identified alcohol as the second most reported substance, and 26% (n=14) identified cocaine as the third most frequently reported substance. Overall, irrespective of the ranking, 94% (n= 51) of all participants identified cannabis as a commonly used substance, 81% (n=44) of participants identified alcohol as a commonly used substance, and 31% (n=17) identified cocaine as a commonly most substance. In terms of those that identified 'other' for the second and third most frequently reported substance, they were asked to specify which substance they were referring to. The one participant that responded 'other' for the second frequently reported substance, identified: "Nicotine (vaping)". For the three individuals who reported other for the third most frequently reported substance, identified: "Xanax", "Benzodiazepines" and "gas".

Effective Interventions for Frequently Reported Substances

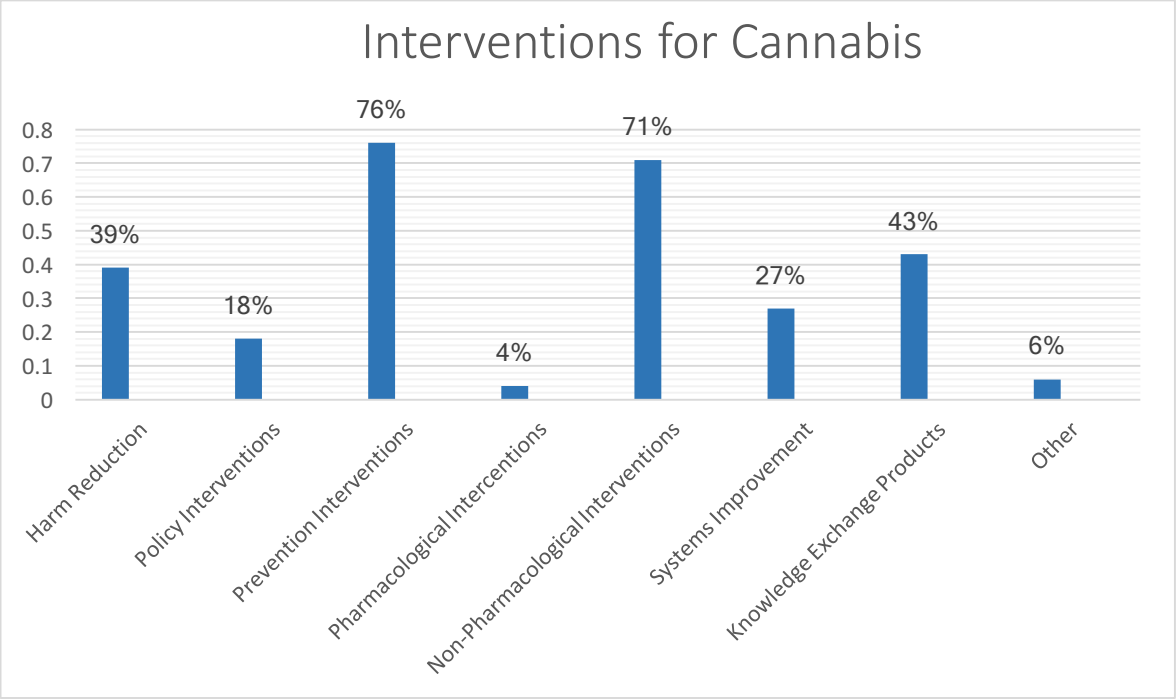
As a follow-up to the previous question, participants were asked to identify which intervention(s) they believed would be the most effective in addressing issues related to the most frequently used/reported substance(s) they identified. More specifically, the question read: "For the substance you identified as #1 (the most frequently used/reported), please identify which intervention(s) would be the most effective in addressing issues related to that substance (select all that apply)". This question repeated for the second and third most commonly reported substance they identified. Since cannabis and alcohol ranked as the top two most frequently reported/used substances among their youth that they serve, I was particularly interested in looking at which interventions were identified to help address issues related to these two

substances. I organized the data to look at which interventions participants selected, if they had chosen cannabis or alcohol as a first, second or third frequently reported substance.

Effective Interventions for Cannabis as a Commonly Used Substance

Irrespective, if they ranked cannabis as the first, second or third frequently reported substance, I collated all the responses, as well as the most effective interventions identified to address cannabis, and grouped them together to get a big picture of intervention approaches generally when working with youth whom frequently use cannabis. It is important to note that participants had the option to select all interventions that they felt would be effective. The results are presented in the table below:

Figure 6:

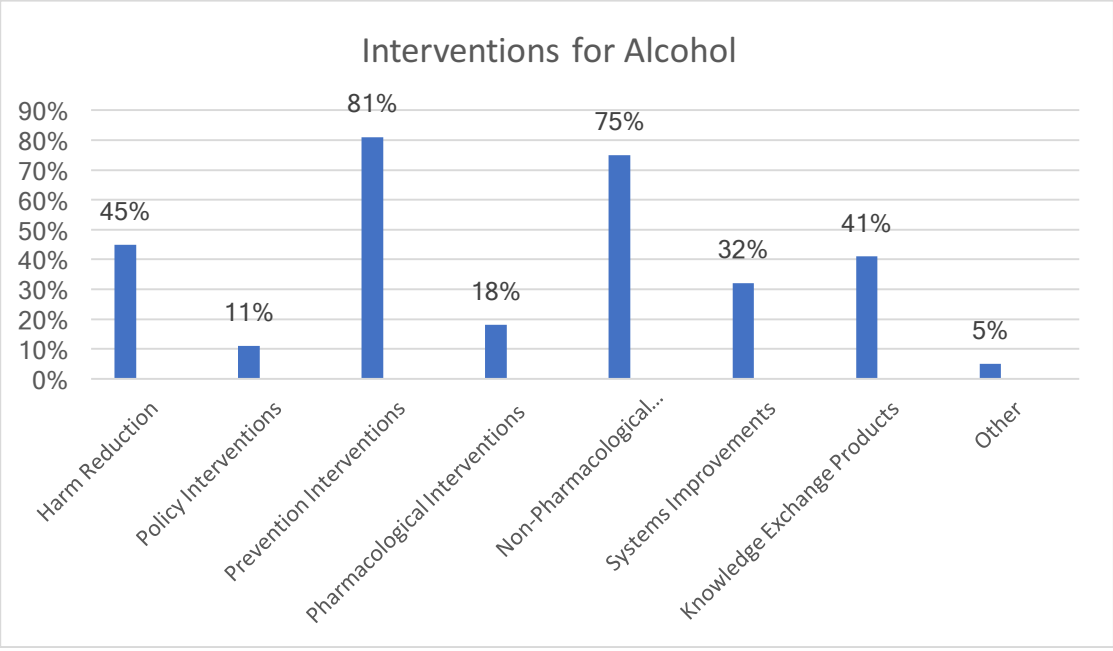


As such, based on the responses, prevention (n=39) and non-pharmacological approaches (n=36) appeared as the most effective interventions when working with youth whom use cannabis, followed by knowledge exchange products (n=22). These intervention approaches listed were very broad in scope, and could include many different types of services under these broad umbrella interventions, such as counselling, education, or early intervention approaches.

Effective Interventions for Alcohol as a Commonly Used Substance

I was also interested in looking at the specific interventions participants selected if they identified alcohol as a frequently used substance among the youth they served. Irrespective, if they ranked alcohol as a first, second or third priority, I collated all the selected interventions and grouped them together to get a big picture of effective approaches identified when working with youth whom use alcohol frequently. It is again important to note that participants had the option to select all the interventions that they felt were effective for alcohol use.

Figure 7:

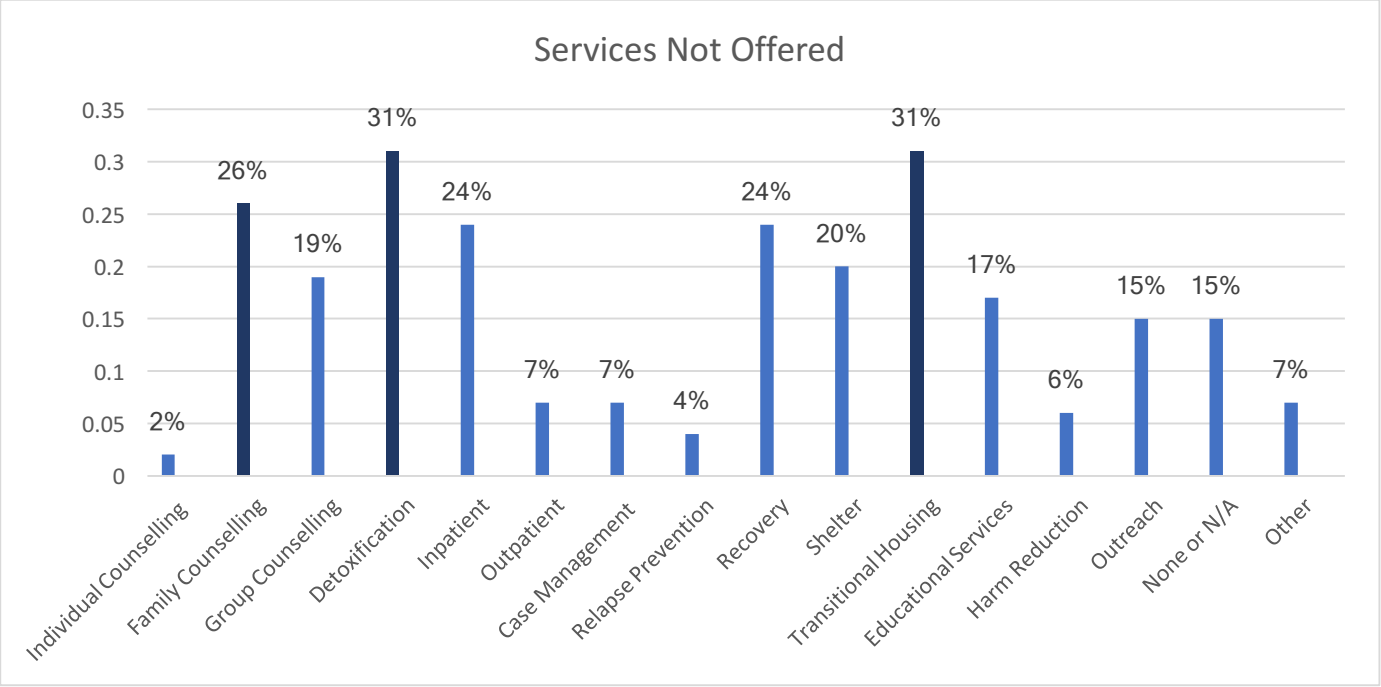


As such, based on the responses received for alcohol, prevention (n=81%) and non-pharmacological interventions (n= 75%) approaches were perceived as the most effective when dealing with youth whom use alcohol. These responses were consistent with the interventions that were identified for cannabis.

Useful Services Not Offered

The next question asked participants to identify which services their organization did not currently offer, but would be useful to offer in the future. Participants were asked to select all that applied from a list of services. The results are identified below:

Figure 8:



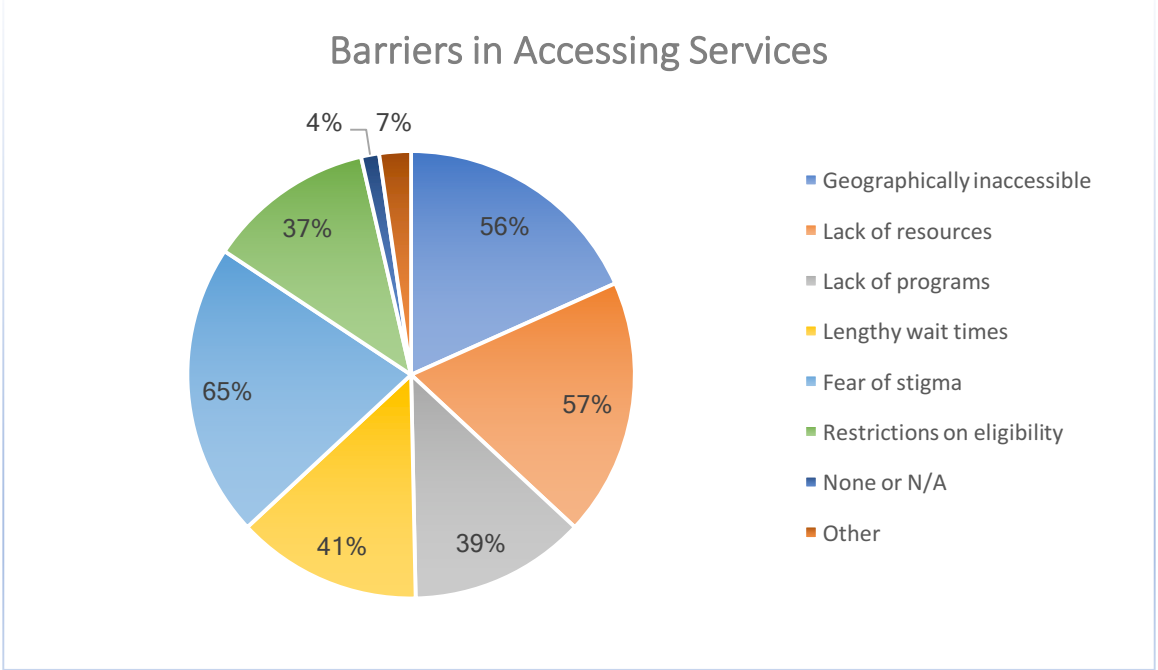
Based on the responses, detoxification (31%) transitional housing (31%) and family counselling (26%) emerged as the top 3 services that organizations currently did not offer but expressed as

useful services to offer. This information helped me understand the gaps in service provision in Ontario, and which services could be useful to offer to youth. In light of this finding, I was particularly interested in exploring this treatment gap further in the key informant interviews, as youth specific detoxification services have been predominantly non-existent in service provision.

Key Challenges

The next questions asked participants to identify the key challenges that youth may face in accessing youth-oriented services in their region. Participants were asked to select all that apply from a list of challenges. Below are the findings:

Figure 9:



Fear of stigma (65%), lack of resources (57%) and geographically inaccessible (56%), were listed as the top three challenges youth face in accessing youth-oriented services. While there is an abundance of literature and research regarding the impacts of stigmatization, and other

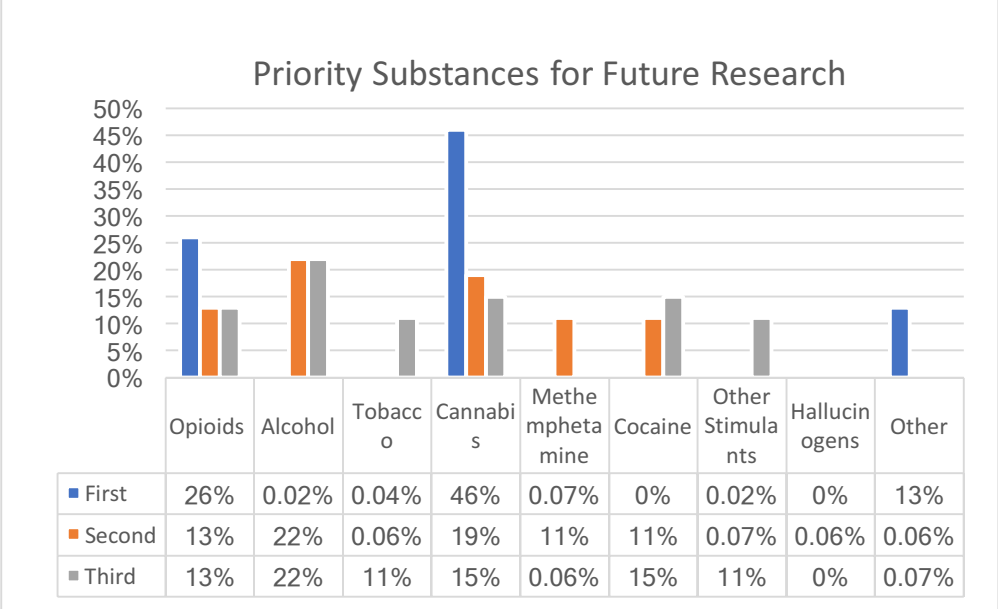
challenges identified by participants related to access, this prompted me to further understand how frontline workers perceived stigma as a barrier, and what they believed would be effective in addressing this issue, to help ensure stigma is removed as a barrier. As such, this was something I wanted to further explore with the key informant interviews.

Of the 3% of respondents who selected 'other' noted issues related to transportation, lack of support from school boards to promote youth services, lack of French-speaking services, and the challenges around wait-times. However, the wait time response, could have been incorporated into the lengthy wait times check-field box provided.

Priority Substances for Future Research

The next question then asked for participants to rank the top three substances they would like youth-oriented substance use research to focus on and prioritize over the next three to five years. I was interested in seeing whether the frequently reported substances they identified in the responses earlier- namely cannabis and alcohol- were consistent with the priority substances they would like to see future research focus on. As such, the findings are identified below:

Figure 10:



	Opioids	Alcohol	Tobacco	Cannabis	Methempheta mine	Cocaine	Other Stimulants	Hallucinogens	Other
First	26%	0.02%	0.04%	46%	0.07%	0%	0.02%	0%	13%
Second	13%	22%	0.06%	19%	11%	11%	0.07%	0.06%	0.06%
Third	13%	22%	11%	15%	0.06%	15%	11%	0%	0.07%

Based on the substances selected, cannabis (46%) was identified as the first priority substance area, followed by alcohol as both the second (22%) and third (22%) priority substance. These findings are consistent with the most frequently reported substances identified by participants. Of the respondents whom selected 'other' as a priority substance, eight of them noted 'vaping', three of them identified 'benzodiazepines', and other substances identified were 'lean', 'mental health medication' and 'prescription medication'. I was then particularly interested in exploring which types of services, and interventions they would like to see in terms of future research in these areas. The responses varied, and as such, I grouped them into the following categories and themes: Community based research (35%); best practice guidelines (33%); clinical research (28%); pilot projects (20%); research (17%); and academic publications (6%). Community based research and best practice guidelines were identified the most in terms of interventions they would like to see in the future.

Overall, the findings presented outlined interesting themes. Firstly, the majority of respondents were frontline addiction counsellors (43%; n=23) where most service providers identified serving approximately less than 50 youth in an average month. Individual counselling (94%; n=51), relapse prevention (81%; n=44), and harm reduction (76%; n=41) were among the top three services offered by the services who participated in the survey. In terms of substances themselves, cannabis and alcohol were the top two substances being reported by youth as identified by the service providers, with 76% (n=41) of respondents identifying cannabis and 54% (n=29) identifying alcohol. These two substances were also identified as priority substances for future research. When asked about effective interventions when dealing with youth who use cannabis, participants identified prevention (76%; n=39) and non-pharmacological (71%; n=36)

interventions as the most effective. The interventions were similar for alcohol, with 81% of participants identifying prevention and 75% of participants identifying non-pharmacological. When asked about useful services not offered, detoxification and transitional housing (31%; n=17) were equally identified as a beneficial service not currently being offered, followed by family counselling (26%; n=14). In terms of key challenges youth face when accessing services, stigma (21%; n=35), lack of resources (19%; 31) and geographically inaccessible (18%; n=30) were the top three barriers identified.

Now that the findings of the survey have been presented, I will draw on the findings from the key informant interviews.

Chapter 6: Key Informant Interview Findings

Out of the 26 participants that expressed interest in being involved in the key informant interview phase, a total of 16 participated in the qualitative component of the study. There was representation from each of the LHINS, where five informants represented the East LHIN, three informants were from the Central LHIN, one was from the Toronto LHIN, four were from the Northern LHIN, two were from the West LHIN and one informant whose services covered all the LHINs. The roles among the informants differed, where three individuals were directors, another three were intake coordinators, two were managers, and seven were either youth counsellors or therapists. This diversity ensured my ability to collect distinct perspectives from participants who had frontline experience with youth.

The earliest age accepted across all services was 12, and the latest cut-off age was 29. The majority of services took youth starting at age 12 until the age of 24. This age range is relatively consistent with the World Health Organization definition of youth as 10 to 24, and Malla et al., distinction of 12 to 25 (Malla et al., 2018). More specifically, based off the responses the average age in which youth were eligible for services was between 12-13, while the average cut-off was generally between 23-24 years of age.

When asked, who was seeking service support, there were quite a few mixed responses; however, the majority of key informants indicated that they rarely received self-referrals from youth, and that when they did receive them, it was mainly among older youth (typically ages 18-25). While some of the programs are voluntary in nature, referrals were usually driven or encouraged by another service provider, or mandated by other services, such as children's aid

society (CAS) or probation. Family (typically parents, caregivers, guardians, etc.) and schools came up as the most common for referring youth to services. With regards to schools, many of the youth services were school-based programs, where they were placed as either part- or full-time programs in schools, and as such, had ongoing access to youth. As an example, one key informant indicated: "Most of them come through the schools. I would say maybe 10% are self-referrals, and the rest come from another source" (Key Informant 13). In many cases, I heard that students who have been expelled or suspended as a result of substances are required to meet with a substance use counselor. Teachers who recognize substance use issues also refer youth to the school-based programs that are available. With regards to younger youth, usually their family would encourage them to seek support, or at least makes the initial connection. For example, one informant described how parents are integral in connecting youth to services: "When it comes to youth, it's more parents. We've had referrals from teachers also, usually youth at that age they wouldn't want to come on their own" (Key Informant 4).

Other connections and referral pathways to services, were friends, treatment programs (such as outpatient mental health programs), primary care providers, social workers or lawyers. Overall, it was clear that youth themselves rarely sought service support, and program initiation was mainly driven through the school system.

Discourse at a Crossroads: Normalization, Stigmatization, and Changing the Discourse

The interpretation of the key informant interviews yielded three salient findings: first, the normalization of the two most frequently reported substances -cannabis and alcohol -by society, family members, and peers, promotes and influences substance use patterns (including increase

in use) among youth. Second, stigmatization stemming from a variety of factors such as traditional and societal perspectives, and family morals is the leading deterrent of access to services by youth; third and last, changing the discourse around substance use to inform and educate users and the public about both the negative health effects of substance use and about the fact that substance use is a health and not a moral issue is necessary as it would help combat stigmatization associated with service access, and ultimately improve service provision and encourage the implementation of youth appropriate services. Notably, and paradoxically, the intersection and combination of both a positive (i.e., normalization) and a negative (i.e., stigmatization) perspective towards substance use led to an overall *negative* outcome, in that both discourses *simultaneously increases use among youth while deterring them from accessing services*. In the following paragraphs, I elaborate on these themes and analyze their implications for equity in youth substance service policy and practice.

Normalization of Cannabis and Alcohol Use among Youth

While the survey responses made it clear that cannabis was the most frequently reported/used substance among the youth accessing their services, followed by alcohol, I wanted to know from a frontline perspective why these substances were deemed as problematic and why these specific substances were as highly reported. The main theme that was central in these discussions related to the 'normalization' of cannabis and alcohol use, within societal, familial, and peer discourse which perpetuates, and at times encourages use.

Key informants expressed how youth attitudes and opinions towards cannabis and alcohol are very normalized, as they perceive these substances to be socially acceptable, widely accepted

and used among their peers, and are 'social' substances that help them 'fit' in group settings or allow them to alleviate everyday stress that they may experience. Key informants mentioned that cannabis and alcohol have become very normalized within society, starting at a very young age, which has contributed to the frequent use. For example, one key informant elaborated on the ways in which cannabis has been normalized and the impact it has on youth:

> It's [cannabis] been so normalized for kids starting at a young age, and seen as a coping tool, I think it is a real issue. I meet school kids at school who go out and smoke because it's better than being alone at lunch, or to cope with stressors at home, peer stuff, self-esteem, I think for young youth its more accessible than some of the other drugs, they see their peers using it more, than they see their peers smoking crack or something. And I think they often don't see it as problematic. (Key Informant 11)

Additionally, key informants indicated that specific effects of 'peer pressure; when it comes to cannabis and alcohol since they are commonly used among youth, and youth often strive for a sense of belonging among their peer groups, leaving them susceptible to feeling pressured to use since their peers are also using:

> Just that concept that they believe everyone else is drinking, that peer pressure to fit in. (Key Informant 15)

Key informants elaborated that cannabis and alcohol are so normalized that many youth do no perceive them as substances, which has implication for treatment and support, particularly if they do not see these substances as problematic:

> Sometimes I'll have conversations regarding other substances and then it's like oh right I smoke cannabis do you consider that a drug? So again, youth are not considering cannabis a drug because of the way they were raised with it and not understanding it's still a drug. (Key Informant 9)

This was further elaborated by another informant whom gave an example of how cannabis is largely not considered a drug when engaging in discussions with them:

> I don't know how many youth have said I don't do drugs, but then they'll say but I smoke weed, and then I'll say well you know that's a drug, and they would say not really, and I would say yes really. So, a lot of them I find that the whole culture is that weed is not problematic, it's not really a drug like other drugs. (Key Informant 11)

Key informants further mentioned that some youth actually perceive the use of cannabis and alcohol as 'safer' alternatives to other substances, and that they do not recognize or understand the potential harms that they can cause, which can directly result in initiation or increased use. This was illustrated when an informant stated: *"*... the perceptions that youth maintain towards cannabis is that it's a low risk and relatively safe, so they have those perceived notions. So, I think that increases the potential for experimentation." (Key Informant 6)

Relatedly, a lack of information and education was frequently mentioned regarding the misconception youth have of cannabis and alcohol being safe and low-risk, and as a result. With respect to cannabis, key informants indicated that many youth think it is a natural substance, aren't really aware of how sever it could be on their mental health and other parts of their lives, as illustrated by one participant:

> I think because they don't know how severe it is, especially with mental health. With cannabis, we have seen a lot of clients here that have come with mental health conditions, and all they do is over consume marijuana and then they go into a psychosis state of mind, which is very dangerous. (Key Informant 4)

Key informants explained that a lack of knowledge on the potential harms of these substances allows youth to minimize the risk and severity of them, and that with cannabis in particular,

many youth are not aware of the different strains and psychoactive components, and the potential it has to lead to harmful outcomes. Key informants expressed concerns regarding the long-term effects on both the brain and mental health, as well as the potential to lead to dependence, and described how youth do not understand or recognize these as potential harms or the ways that cannabis use can lead to problematic outcomes. Other key informants expressed concern regarding the lack of knowledge on the ways that cannabis may be a gateway substance and lead to other – potentially worse- substance use. For instance, one informant described the detrimental risks associated with cannabis use, as well as the potential for cannabis to be utilized as a gateway substance:

> It's [cannabis] absolutely problematic, because I think they're minimizing the risk of it because many of them think that it's a natural substance. And secondly, they don't think you can die from it, so it's not seen as harsh. And I think the problem is many people who I end up supporting longer term down the road I find it a gateway drug to other substances, that's what I'm finding. (Key Informant 7)

Importantly, the legal status of cannabis and alcohol was discussed as a key factor that specifically contributes to normalization of these substances and ultimately promotes use. Not only does it make these substances more socially acceptable, it can cause confuse youth who believe that since they are legal and people commonly use them, then they must be safe, as explained by one informant:

> It's just very accessible. I think that with both being legal, especially in the youth mind, I just think that because it's legal they think that there's nothing wrong with it, because why would it be legal if it was bad for you? (Key Informant 14)

Key informants also mentioned that since cannabis and alcohol have both been very normalized within society, starting at a very young age, there is an attraction to it from the youth's perspective. For example, when asked why they thought cannabis was the most frequently used

substance, one key informant emphasized the social acceptability of the substance, which leads to the increased availability and use:

I believe it's [cannabis] the highest using substance because of availability, because of it being normalized in our society as something that's acceptable, because young people find that it doesn't impair them the same way that alcohol might or other substances, so they feel functional in their use. (Key Informant 5)

Key informants also mentioned the ways in which accessibility contributed to substance use among youth. Specifically, since cannabis and alcohol were often used by family members or siblings, youth are customized to seeing their family use them, and the substances are easily accessible and available within the household. There were a lot of discussions looking at parental alcohol use, not only reflecting an acceptability towards it, but also increasing the access and availability of it. The fact that many parents, caregivers, or older siblings were seen consuming alcohol frequently, inevitably contributed to an adolescent deciding to use. In fact, many respondents mentioned how parents do not perceive alcohol use as a problem, and tend to purchase it for their underage kids for parties or social gatherings. This issue of access was also noted by a key informant when discussing alcohol use:

I do feel it's so easy to access it, I mean yes in Ontario the law says 19 years old but it's easy to have an older friend, or sibling or ask somebody off the street to get it, or your parents have a cupboard full of it. I think it's accessible. (Key Informant 9)

Relatedly, another key informant elaborated on how parent perceptions and use of alcohol was indicative of acceptance and normalization, and perpetuated use:

Even when I talk to parents, the parents don't see the fact that oh yeah I got my kid some alcohol for this party, as problematic or questionable behaviour. It's so widely accepted by everyone, not just the youth but by their parents, their friend's parents. (Key Informant 12)

For many of the youth that have developed alcohol-related issues grew up in an alcohol using family, and as such they have been impacted by their parental use. One participant described the connection between alcohol use and family use:

> The youth who I find who I have supported, but what they are challenged with, they are impacted by their parent, their parental use and that impacts their use. There's a big connection with alcohol use within the family, and now they're struggling with it as teenagers or as a young adult. (Key Informant 10)

<u>Stigmatizing Discourse around Cannabis and Alcohol Use among Youth</u>

While key informants indicated that the normalization of cannabis and alcohol use among youth contribute to increased and frequent use among youth, they also discussed that stigmatization deters youth from seeking support for their substance use. Based on the discussions with the key informants, it became clear that among all the barriers and challenges which impede on youths' ability to seek service support, stigmatization was at the forefront. Participants explained how stigmatization of substance use, including traditional, personal, and/or familiar perspectives, directly impact youth's feelings towards and decisions on whether they should seek substance use service support. These areas will be further elaborated below.

Traditional Perspectives

Key informants identified traditional viewpoints held among the majority of the general population regarding substance use as the biggest factor contributing stigmatization. Primarily, it was conveyed that society typically holds negative perceptions towards substance use and have a lack of understanding and knowledge regarding substance use. In particular, the common belief that substance use is a choice and therefore a social or moral failing among users as opposed to a health issue, contributes to stigmatization and prevents youth from openly discussing their

substance use and/or seeking support for it. Additionally, key informants indicated that these traditional perspectives also continue to be held by many healthcare and other frontline service providers, which contributes to stigmatization. For instance, one informant expressed the extent to which the substance use realm is severely stigmatized:

> I do think that kind of within various kinds of treatment settings, particularly healthcare, substance use in general is probably one of the more stigmatized areas. You know I think mental health is sort of becoming more accepted, but I still see that substance use, there's lots of associations, negative associations and judgments that get made around you know, sort of drug user, all the kinds of words that get used around people that are using drugs. (Key Informant 16)

Key informants elaborated on how systemic perceptions and stereotypes around substance use remains prevalent today. For instance, youth continue to be taught negative lessons and connotations about substance use such as 'drugs are bad' and 'drug use is wrong'. These perspectives are therefore instilled from a young age and not only deters youth from feeling comfortable to have conversations about substance use or seek support from their family or services. One informant explained how shame and guilt impacted youth from seeking service support:

> It really comes down to being shameful and guilty. I think shame is a huge piece that's a massive barrier. You've been told your whole life that drugs are bad, don't do drugs, and then people are ostracizing you, or shunning you, or treating you poorly and not supporting you because of the choices that you're making. (Key Informant 10)

Additionally, the legal vs illegal substance conversation also perpetuates stigma, because when something is 'illegal' there are many traditional negative connotations and perceptions associated. This was the case with some illicit substances, but this issue was also presented with

cannabis and alcohol, as many youth who used such substances were underage. This was illustrated by one informant:

I think the whole legal, illegal thing that definitely plays a role, they recognize that this is not something that is legal for my age group, so I think they are less likely to engage in those conversations with adults, because that's the first message that they hear, well you can't do that, that's illegal, that's not an OK thing for you to do for your age. (Key Informant 6)

Familial Perspectives

Another major theme that was discussed by key informants in relation to stigmatization was familial or cultural pressure. Many key informants expressed that youth fear being ostracized by their family for admitting that they have a substance use problem and/or seeking support for their use. Compounding this issue are cultural-specific norms and traditions, where many youth in Ontario are first-generation Canadians who commonly have parents and families that hold conservative or traditional cultural perspectives, which heavily forbid or look down on substance use. Respondents indicated that this contributes to fear of stigmatization among these youth, and these household standards and customs commonly impact youth's willingness to discuss their substance use and discourages them from accessing support, services, or treatment:

Stigma is coming from the young person's family, they are going away to treatment, how are we going to explain to our family, friends, neighborhoods, that you're going somewhere for 3 months? (Key Informant 08)

Personal Perspectives

The last theme that arose around stigma related to personal attitudes and perceptions. Many respondents explained that youth commonly did not seek support when needed because they internalized feelings of guilt and shame, and perceived that something was 'wrong' with them if

they needed help for their substance use. Participants explained that youth are often afraid to be judged by their peers for seeking help, since they do not want to look 'inadequate', 'weak', or 'uncool'. For instance, one key informant explained how judgement within the adolescent age group is prevalent, which can impede their desire to access or receive appropriate support: "…because they don't want to be judged by their peers and they worry about looking 'weak'." (Key Informant 11)

Key informants also noted the difficulty youth may face in accepting or understanding that they have a substance use problem. Youth may not comprehend the complexities (including the biological, psychosocial and social intricacies) of addiction, nor why they may be more susceptible to problematic use than their peers. Participants indicated this can also increase the tendency for youth to hide their problems since they do not want to appear different than their friends, and are reluctant to openly discuss their issues:

> They don't want to identify that they have a problem. I see a lot with clients, ask why can my friend just have a couple drinks, and why can't I be ok doing that? It's hard for them to understand that they have addictive personalities and addictive traits, and that's why a couple of drinks wouldn't be enough for them because their addicted to it. (Key Informant 4)

There was also apprehension and hesitation that if they sought services, other parties would get involved, such as family or the police (especially if they were engaging with illegal substances). Fear also played a role, as they were scared they would get in trouble by their parents, employer, school if they were 'caught' having a substance use issue. One respondent provided a key example of the fear and hesitation youth may feel:

If I go and tell my problems to this person then I am going to create bigger problems for myself. They fear that child and family services might be involved or police. They create this vision that oh my god, if I share this with somebody then it's just going to blow up in my face. (Key Informant 9)

Amid these conversations, it became clear that changing the substance use service delivery to promote youth education on the issues related to use could help youth identify the severity and potential consequences that could come from engaging in substance use. Improving service provision could also work towards removing stigmatization to help ensure that youth are not deterred or afraid to seek the support they need, when they need it. As such, discussions around ways to improve service provision and combat stigma arose, which was directly related to changing the discourse and improving service provision by integrating educational components of substance use and removing structural barriers which may perpetuate stigma.

Changing the Discourse

In relation to the traditional perspectives of substance use which perpetuates and reinforces stigma, many respondents expressed the importance of changing the discourse and shifting how substance use is perceived and understood. Key informants suggested the need to focus on normalizing conversations around substance use so it can be spoken about openly, including in schools, community centres, hospitals and households. Respondents stated that it is important to reconceptualise substance use from a moral failing to understanding that people who have a disorder have a health condition just like any other health issue, and as such, shift the discourse to look at substance use from a health perspective. Key informants discussed the need to increase public awareness about substance use, as well as reformulate connotations so that substance use is not always perceived as inherently 'bad', which would allow youth to feel more comfortable

and inclined to seek support regarding their use. To highlight this, one respondent emphasized the importance of framing substance use as a health issue:

> Taking a look at it from more of a health perspective, because I don't think socially, addiction or substance dependency is really viewed as a health problem…. You can get around these things by identifying the treatment as a health-related need, in actuality that's exactly what it is, and just trying to reinforce it. (Key Informant 8)

Another informant further discussed the importance of changing the discourse of how substance use is traditionally perceived by normalizing the topic in conversations:

> Traditional perspectives and viewpoints and stigma play in, and it's been a constant for as long as I've been in the field. What could help support a change in that is conversation shifting how substance use is perceived, how it's understood and normalizing the supports in conversation in schools, in community centres, hospitals. Just bringing that into the conversation helps normalize it, which is traditionally, you wouldn't be able to raise this topic without raising blood pressure. (Key Informant 1)

In order to help refocus these conversations (including educating youth about the risks of substance use) and shift the discourse from traditional perspectives to a public health lens, many respondents explained how substance use discussions should be entrenched within the education system. This would not only bring awareness, but it would also normalize conversations about substance use. Specifically, respondents emphasized the importance of educating youth by having open discussions on substance use as part of educational curriculum, starting from an early age, which would encourage schools and youth to talk more openly about it, as illustrated by one key informant:

> If it's part of the curriculum and discussed as openly as any other subject that's important, as an important life skill to learn how to cope, I think there would be open conversations and less stigma around reaching out for help. (Key Informant 11)

Key informants also acknowledged the need for continual education, from an early age right through the entirety of youth's educational trajectory, which would reinforce the notion that it is okay to ask for support:

I think that it should be more openly spoken about in high schools, even in universities and colleges. If they make it seem like it's ok to have a problem, more people would be open to get the help. (Key Informant 4)

The school system was discussed by key informants as the perfect place to provide education towards normalizing support seeking, including the use of psycho-education and after school programs, since youth spend the majority of their time in schools. This outreach and accessibility piece in the school system was explained by one key informant:

Regular outreach in the schools where you're more accessible, where kids are. More education about the drugs as part of the curriculum, after school programs where they can come and talk openly without worrying about consequences. (Key Informant 11)

Such a system-level change in the education system could help inform youth on the risks associated with use while simultaneously combatting stigma by reframing the understanding and perceptions around it. Starting the educational process early would be additionally beneficial as it would allow for early intervention and proactive prevention of substance use issues, which is crucial considering the earlier one is able to intervene, the earlier the problem can be addressed, as highlighted by one respondent:

Early intervention, we know that the earlier you intervene, you can address the problematic substance use before it progresses to a more serious concern, the better the outcome. (Key Informant 6)

Another participant emphasized the importance of providing this early-intervention piece:

> Education, earlier than high school. Because I am seeing a lot of people in grade 9 and it needs to be, even in grade 5/6 starting there, and carry on to 7/8. Because I think a lot of my clients have already tried it in grade 7/8, somewhere along the lines they've used it already, it's unusual for someone to say that they've just tried it in grade 9. (Key Informant 13)

The significance of incorporating substance use into the school curriculum was also exemplified by another respondent:

> If it's part of the curriculum and discussed as openly as any other subject that's important, as an important life skill to learn how to cope, I think there would be open conversations and less stigma around reaching out for help. (Key Informant 11)

There is also the need to ensure that not only service providers are trained with the appropriate information, but teachers are as well. It is important for teachers to have those conversations with their students, and direct them to appropriate services, if needed. It was also discussed the importance of providing substance use education in the school system, integrated into the curriculum. This ties into the early-intervention piece, where respondents identified the need to be proactive, and start the educational process early. The earlier one is able to intervene, the earlier individuals can address the problem, before it progresses, as detailed by one informant:

> The early intervention, we know that the earlier you intervene, you can address the problematic substance use before it progresses to a more serious concern, the better the outcome. (Key Informant 6)

Another participant emphasized the importance of providing this early-intervention piece in elementary schools:

> Education, earlier than high school. Because I am seeing a lot of people in grade 9 and it needs to be, even in grade 5/6 starting there, and carry on to 7/8. Because I think a lot of my clients have already tried it in grade 7/8, somewhere along the lines they've used it already, it's unusual for

someone to say that they've just tried it in grade 9. (Key Informant 13)

Beyond school-based education, public health educational campaigns were also discussed as important interventions, especially related to cannabis and alcohol. Key informants expressed a need to raise public awareness thorough social media campaigns providing youth-friendly and receptive tools, tips and information regarding substance use, effects, and safe ways of using. Informants discussed the importance of providing this education in a way that is targeted specifically for youth, prompting them to gather the accurate information regarding substance use. The effectiveness of social media platforms was expressed by one participant when the following recommendation:

I think definitely public awareness through social media, that's something that youth have been asking for, they're like why don't you do those Instagram or snapchat ads, we actually read them if it's something that's for us… You have to think of where they are spending their time, they are spending their time online. (Key Informant 10)

Improve Service Access and Delivery

In addition to changing the discourse around substance use, services themselves can play a role in reducing the stigma that may be associated with service access. The need for more youth-specific services designed and developed in appropriate and meaningful ways was frequently discussed by key informants. Specifically, suggestions to reduce the structural barriers which contribute to stigma, such as abstinence-based or age of consent restrictions. This could be achieved by involving youth in the development of services, ultimately working towards reducing the stigma surrounding service provision from the perspectives of youth. The importance of ensuring that youth-oriented services are not only accessible but also developmentally appropriate was also frequently discussed. Respondents emphasized that youth

services should work towards ensuring that the process of accessing services is as seamless and easy as possible, reducing the number of potential barriers. For instance, one informant provided detailed account of the systemic challenges that youth face simply to access a program:

> But it's what they have to do to get in, they have to phone, talk to somebody, set something up, and that in of itself can also be a barrier in terms, and certainly related to stigma, because I have to make that call, but it's also the processes involved in getting them to a service right. (Key Informant 5)

The need to ensure that there is reduction in barriers of entry is critical. One informant described this need, outlining the various structural barriers that may deter youth from seeking services:

> Not just that we have an intervention, we have to think of how we offer the intervention in a way that it's likely to be uptake. Think about engagement, we could have the best intervention, but we only offer it every day at 8-9 AM, and you need to wait 3 months for it and you need a referral, and we want your parents to come. I think we do know a bit about what are youth centred services. (Key Informant 2)

Key informants also mentioned the importance of having youth specific services, grounded in a harm reduction approach. Organizational policies should be reflective of this approach, and should minimize the barriers associated with accessing services/treatment, in terms of how the service is set up and the environment in which the service is fostered (warranting that it is welcoming and does not maintain stigma) ultimately endorsing the harm reduction approach. The importance of enforcing harm reduction approaches in youth services, was expressed by one participant when they explained: "I think it really just falls down to working closely with the harm reduction pillars, so what does that look like in terms of treatment, prevention, enforcement." (Key Informant 10)

Ensuring that services are built on a continuum of care- meeting youth where they're at in life- was alluded as extremely fundamental in order for youth services to be successful. Guaranteeing

the continuum of care model and meeting youth where they're at was explained by one participant when they stated:

> Providing that whole continuum of care, like it's not just one thing or the other, it's looking at let's provide a continuum of care, lets provide a care model that's based on where you're at with your stage of change. So, it's making sure that the service matches, where a young person is at in terms of their readiness for change. (Key Informant 5)

Another informant expressed similar views on how services should grounded in harm reduction approaches, ensuring that youth are not afraid of getting the support they need:

> My organization is very harm reduction based approach, putting it out there that you don't have to make all these major changes to seek support. You can want to just come in and talk about how to use safer, or instead of the idea that you have to quit to get help, which I find that a lot of people are really afraid of, like if I don't make my goals, what are you guys going to think of me? (Key Informant 12)

Specific harm-reduction interventions discussed as effective for youth were psychotherapy, motivational interviewing, and goal setting services. Peer groups were also noted as effective, having lived experiences of youth. There was also discussion regarding outreach and health promotion in schools, grounded in harm reduction approaches. These examples of interventions were described as less-stigmatizing and welcoming, to ensure that they are appropriate for youth and that youth are comfortable to seek the initial support.

Clinical treatment was also discussed, and the need to have more outpatient and inpatient youth treatment options. This was especially relevant for detoxification and withdrawal management services. The main concern that was brought up regarding detoxification services across all the key informants was the fact that there were no youth-specific detoxification services available. The fact that youth don't have the opportunity to access detoxification or withdrawal

management services because of age constraints sparked concern and frustration among many of the respondents. For example, one informant highlighted how there are currently gaps in services due to the fact that detox services aren't available to youth under the age of 16:

> There is no such thing as detox services for anyone under 16. They don't exist. So, when I have a client, 13, 14, or 15 year olds that are abusing things like cocaine, benzos, there's no option for them… there is certainly a gap in services. (Key Informant 8)

Some informants mentioned the need for detox to be available for any youth that requires services, regardless of their age. Informants expressed that they didn't know where to send youth when they are needing detoxification services, albeit the amount of youth that require services may be low. Another informant mentioned that while their community has access to one detox service for youth who are over the age of 16, if they have younger youth, they had nowhere to send them to:

> We lack services for youth, especially here in the North, we have one detox facility and the age is 16 and over, which is fair however if you have younger youth who are using stronger substances, they have nowhere to go. (Key Informant 9)

Some informants mentioned that they did have access to some detox services (not youth specific), but they were located in different parts of the community, and sometimes very far away from where the youth resides. This again creates additional barriers and challenges for youth, as often times, youth do not want to be removed from their home environment for a long period of time, as it could be very traumatic. Additionally, in some instances when youth were sent to adult detoxification programs in desperation, it was described as scary and traumatic. The services needed for youth are completely different than those required for adults, and as such

creates a non-conducive treatment environment. For instance, one informant provided a key example of the fear and trauma that youth may experience accessing an adult detox service:

> It's kind of scary for a young person to go into an adult detox right, and it can be very traumatic in terms of what can be witnessed right, so I think some of the challenges have been having youth specific withdrawal management services, whether that be community based or residentially based, but they are designed for young people. (Key Informant 5)

Since an overall lack of services was identified as a barrier, key informants also described the need for residential treatment options for youth under 18. For instance, one respondent expressed: "There's just not enough services for youth. It would be great to have a treatment centre up here for kids under 18." (Key Informant 11)

Overall, the relevance of discourse played a big role in the interpretation of the key informant interviews. While discourse which alluded to the normalization of cannabis and alcohol use contributed to increased and frequent use of those substances, discourse related to the stigmatization of substance impeded on youths' decisions on whether to seek service support. However, based on the interviews, it became clear that improving service delivery to include educational components within the school- system, and removing structural barriers to service access, while delivering youth-appropriate services, has the potential to change the discourse. With the findings from data collection presented, I will now engage in the WPR to examine the ways in which substance use issues are represented in the national CDSS document.

Chapter 7: 'Critical Policy Analysis Findings

What's the 'problem' represented to be in the Canadian Drugs and Substances Strategy (CDSS)?

In the following section, I will critically examine the CDSS using the WPR framework. The CDSS can be found online on the *Government of Canada's* website, and characterizes itself to be "a comprehensive, collaborative, compassionate and evidence-based approach to drug policy" (Government of Canada, 2017). The landing page outlines the four-pillars and offers a link to discuss each pillar in more detail. While the details regarding the CDSS in terms of endorsement, the goals, and performance indicators are not easily accessible online, more details can be found on a separate link on the Government of Canadas website: *Supplementary Information Tables 2018-2019 Departmental Plan: Health Canada*. The CDSS initiative was launched on April 1, 2017 and states that the end date is in years 2021-22 and ongoing, indicating the commitment to continue under the same framework and mandate (Government of Canada, 2018b). The webpage is organized to first outline the funders of the CDSS, followed by a brief description of the strategy including the integration of the four-pillars. Shared long-term goals and performance indicators are also presented in the document.

The following questions from Bacchi's checklist, were used to guide my WPR analysis and investigation (Beasley and Bletsas, 2012a):

1. What's the 'problem' represented to be in a specific policy or policy proposal?
2. What presuppositions or assumptions underpin this representation of the 'problem'?

These questions helped me understand how the 'problem' of substance use is represented in the CDSS document, and what assumptions around substance use are made through these representations. By dissecting the strategy, including the shared long-term goal and select performance indicators, a number of interesting themes emerged.

Development and Endorsement of the CDSS

When reading the CDSS, the four-pillar approach is at the forefront, emphasizing the adoption of a compassionate and multidisciplinary approach in addressing substance policy in Canada. However, the WPR analysis uncovered the government's approach towards handling such issues. The CDSS is supported by Health Canada and 14 other federal departments and agencies: Canada Border Services Agency; Canada Revenue Agency; Canadian Institutes of Health Research; Correctional Service Canada; Indigenous Services Canada; Department of Justice; Financial Transactions and Reports Analysis Centre of Canada; Global Affairs Canada; Parole Board of Canada; Public Health Agency of Canada; Public Prosecution Service of Canada; Public Safety Canada; Public Services and Procurement Canada; and Royal Canadian Mounted Police; further emphasizing Canada's current multi-sectoral approach to addressing problematic substance use (Government of Canada, 2018b). However, it is interesting to note that only two of these federal partner agencies are specifically health-related organizations (Canadian Institutes of Health Research and Public Health Agency of Canada), while the remaining agencies are overwhelmingly focused on security and enforcement, having very minimal relation to substance use. Seven of the agencies are focused on legal and law enforcement measures: Canada Border Services Agency, Correctional Service Canada, Department of Justice, Parole Board of Canada, Public Services and Procurement Canada, Public Safety Canada, and Royal Canadian Mounted

Police, while four agencies are focused on finances and the economy: Canada Revenue Agency, Financial Transactions and Reports Analysis Centre of Canada, and Public Services and Procurement Canada. The remaining Indigenous Services Canada agency is intended to support Indigenous policy-making, and Global Affairs Canada focuses on international relations.

The implicit representation of the problem here is that substance use issues need legal responses or answers that do not fit under a health umbrella, which is why 86% (n=12) of the departments which endorse the CDSS are involved in other non-health related areas, and more specifically, 58% (n=7) of them are strictly related to enforcement. These implicit representations will be further illustrated shortly when looking at the long-term goals of the document. While the strategy overall echoes the strength of all pillars, by simply looking at the federal partners, it is clear that the primary pillar is enforcement, revealing the government's true perspective of the problem. This indicates that substance use problems are largely represented and conceptualized as security and legal issues, as opposed to health issues, further supporting the 'war on drugs' framework. This is counterproductive and ineffective because it does not address the root causes of substance use, nor the health-related outcomes, and has the potential to lead to more stigmatization of substance users (i.e. via criminalization). This completely contrasts the cohesive four-pillar approach, highlighting that substance use problems are problematic and require multiple criminal, financial and legal agencies to adequately handle such issues. While the proposed solutions may seem appropriate to the substance user and the general community, through the language used, the reality is that these organizations and partners are tackling substance use issues with a stern legal lens, directly countering the 'official' approach of the strategy.

Since substance use is represented in this light, the following assumptions can be made: substance use causes problematic and illegal behaviour, including the violation of laws; substance use can lead to violence and requires security to manage it; and substance use is more of a legal matter than a health issue. I find this problematic, as it disregards the well-known health-related causes of substance use, and demoralizes the user and the factors related to use.

Additionally, health issues require health responses. As such, strategies and goals related to substance use should be determined primarily by health organizations/agencies since they have the foundational knowledge and understanding to truly work in the areas that best support the health of those who use substances. Furthermore, by looking at the organizations which endorse the CDSS and their predominately law-and-order professional mandates, it is clear that their position is not always aligned with frontline health care worker perspectives that favor the health and well-being of people who use substances, and urge multidisciplinary health interventions to address substance use issues. The glaring lack of health-related agencies, including the absence of any frontline health care organizations' input or endorsement of the CDSS, reinforces the implicit representation of substance use as principally a legal issue. This further weakens the legitimacy of health organizations and their ability to bring real solutions to the table, which is especially problematic as it is the health organizations themselves whom have the frontline experience that would benefit and add value in the development of certain policies in the area of substance use. The sheer number of non-health care-related endorsing agencies is a clear indication of the ways in which the 'security and enforcement' lens supersedes the 'health' lens in the public's eye, and works to engrain the dominant discourse of substance use as being highly correlated to criminal engagement.

Long-term Goal of the CDSS

The contrast of the four-pillar approach is also seen in the long-term goal of the strategy. While each federal partner agency has outlined their respective performance indicators and targets, all partner agencies share one long-term goal:

> Reducing problematic prescription drug use; Reducing demand for illegal drugs in targeted populations and areas; Reducing negative health and social impacts and crime related to illegal and problematic prescription drug use; Reducing supply of illegal drugs; and Reducing the negative health impacts experienced by people who use drugs. (Government of Canada, 2018b)

As seen above, many of these goals explicitly speak to the reduction in the supply, demand and distribution of illegal drugs, and crimes associated with illegal drugs. On the surface, the reductions in these areas seem like good public policy - one that is balancing the needs of both the individual and the public. However, the goals themselves are implicitly very negative and stigmatizing, and do not necessarily speak directly to the health and well-being of substance users. Rather, the focus seems to be largely on the negative outcomes associated with substance use and harp on the enforcement lens, as opposed to the ways in which the pillars - collaboratively- can work with substance users to ensure that their health is prioritized and protected. The ways in which these indicators are presented also display a negative and stigmatizing tone, focusing on the 'reduction' of demand, supply and 'negative' experiences, further harping on reducing or deterring substance use, which has an underlying 'abstention' tone and sentiment (i.e., with the ultimate goal of reducing use, supply and demand until it is no more). While the 'compassionate' discourse would want people to believe that they are working to reduce the negative health outcomes linked with use, the goals (and words) themselves prove otherwise. The inherent understanding of the issues related to substance use in this strategy implicitly relay back to the idea that one should not engage in substance use, and therefore a

focus on reducing both demand and supply should be prioritized, which also highlights aspects of the prevention pillar. As such, the implicit representation of the problem is that there are no solutions to substance use that exist outside of reducing supply and demand- essentially, stopping substance use altogether. And in order to achieve this, heavy involvement from the criminal justice system is needed. The explicit representation of the problem here is that unless we reduce supply, demand, use of prescription drugs, and crime related to illicit substances, then we cannot solve substance use issues. This indirectly guides the public and the reader to believe that any use of illicit substances is essentially problematic and potentially dangerous as it will result in crime or negative health and social impacts.

Performance Indicators of the CDSS

Similarly, the performance indicators outlined in the strategy are used to measure the effectiveness of the shared long-term outcomes of the federal partners, as mentioned above. To reiterate the intent of reducing supply, demand and use, the indicators focused explicitly on deterring or delaying the onset of use, and the appearance of illicit substances, as opposed to looking at the systemic factors associated with onset of use, as well as ways in which strategies can help support individuals through harm reduction and treatment measures. For instance, this is clear by looking at three specific performance indicators used to measure the success of the goals:

> Extent to which strategy activities have, or are contributing to, reduced demand for illegal drugs (e.g. deterred or delayed onset of use among populations targeted for prevention); extent to which Strategy activities have, or are contributing to, a reduction in crime related to illegal drug use in targeted areas; extent to which strategy activities have, or are contributing to, a reduction in the supply of illegal drugs within Canada. (Government of Canada, 2018b)

The underlying assumptions that can be made about the above-mentioned problem representations reiterates that substance use essentially occurs when people engage in illicit

substance use. It again implicitly speaks to the fact that harm reduction and treatment pillars are not really prioritized, as methods to support users from harms associated with use are not outlined, nor are any specific 'harm reduction' related performance indicators. As a result, the performance indicators contradict the four-pillar approach as they inherently support abstinence, which is the opposite of the principles of the harm reduction approach and pillar. This is also in great contrast of the key-findings from the surveys and key informant interviews, where harm reduction as an approach was predominately highlighted as both effective and needed by frontline workers.

While the WPR has exposed how the Government intrinsically frames substance use issues, and implicitly challenges it to be a health issue, there are a number of different analyses that can be made. While not explicitly outlined, the gaps in the strategy reveal multiple problematic stories.

The Story behind the Story

Below I take a deeper look at what is missing from the CDSS. I have found that the CDSS further contrasts the perspectives of frontline workers as well as the four-pillar approach, by not including key messages. Instead, the CDSS largely promotes an abstinence-based tone, neglects the SDOH and the need to address at-risk populations.

Missing Conversations- Lack of discussion around the SDOH

When examining the goals, targets and funding distribution in the CDSS, there is no focus, priority or research designated towards supporting the understanding of the impacts of the SDOH on substance use, which research has proven plays an overwhelming role. In fact, in the CDSS,

the outcome of the harm reduction pillar is to "reduce risk-taking behaviour among people with problematic substance use" (Government of Canada, 2017). Seemingly, the focus on harm reduction does not focus on the effects of certain SDOH; rather it focuses on risky behaviours related to substance use. The overwhelming focus on risky behaviours in the strategy discreetly implies the need for individual behavioural change, and for individuals to make better decisions related to their use. This largely undermines the critical role that the SDOH play. By completely neglecting to include the SDOH, the issue of substance use is being presented as one that does not relate to social and economic factors, and therefore exists independently of these. The assumptions made through these goals imply that it is not necessary to look at the systemic factors and the role of the SDOH when understanding substance use, and instead the focus is on changing individual behaviour. The problem of substance use is then represented in a way that is behavioural and thus assumptions can be made to put the blame on the individual and their choices, as opposed to other social, cultural and economic factors, further supporting the need for a criminal justice framework to address the individual behaviour.

The lack of focus on the social, economic and political impacts, and the explicit statements that speak to how risk behaviours can be reduced, how treatment options to treat substance users can be implemented and the methods to prevent substance use altogether can be identified, again implicitly places the blame on the individual. This further validates the rationale that individuals can either make right or wrong decisions related to their substance use, and no other factors contribute to their use. Inadvertently, this plays a role in the ways in which individuals can be stigmatized for their 'choices' related to substance use, and thus provides the underpinning assumptions that are made within the strategy that substance use is a deliberate choice, and those

who engage in substance use are engaging in risky and problematic behaviour. Under this perspective, the general public can be convinced that substance use is wrong and enforcement mechanisms to 'change' or 'correct' behaviour is thus the only appropriate response.

This gap of the missing conversations around the SDOH was identified when the Government ran a consultation: *Consultation on Strengthening Canada's approach to substance use issues* from September 5, 2018 to December 4, 2018, whereby the consultation asked Canadians for new and innovative ideas on how to further strengthen the CDSS by publishing an online questionnaire from Health Canada to seek input from Canadians (Government of Canada, 2018a). The consultation identified the issues related to the need to address root causes – the social determinants of health- to truly understand the initiation and problematic substance use. However, the extent to which this has been integrated into new strategy development is unclear, as there is no revised national CDSS to reflect these recommendations.

Substance Use is not a Youth Issue

There is also no discussion in the strategy on marginalized and vulnerable populations, more specifically youth, with the exception of Indigenous Peoples, further negating the different economic and social impacts that various populations face when it comes to substance use. Moreover, by mentioning Indigenous populations, but not acknowledging or examining the ways in which colonization and/or historic policies continue to contribute to the specific SDOH that impact them and may perpetuate their use, reinforces the idea that substance use is a personal choice, disregarding other factors and insinuating that their service needs are the same as other populations. For instance, the CDSS says: "With ongoing CDSS investments, First Nations and

Inuit Health Branch (FNIHB) plans to maintain the availability of, and access to, effective treatment services and programs for First Nations and Inuit populations in areas of need" (Government of Canada, 2018b). Due to the lack of discussion around specific at-risk populations, it can also be assumed that the recommendations are largely generalizable and a one-sized-fits-all approach to addressing substance use can be successful. This undermines the various and multidisciplinary issues that different populations face, and specifically excludes the SDOH that may contribute to an individual's substance use. Moreover, it undermines the four-pillar approach and findings from the frontline workers, which call on different interventions to address substance users depending on where they are at with their use.

The lack of discussion around youth further implies that the issues related to substance use are entirely adult problems, and do not require a tailored approach to work with youth whom use substances. The underpinnings within this strategy is that either youth do not use substances and therefore ways to address use among them do not need to be included, or that youth should not engage in any form of substance use, as there is no appropriate response, aside from criminalization. Furthermore, out of all the federal partners, only the Department of Justice mentioned youth, whereby some funding of $26,114,005 would be allocated towards a Youth Justice Fund in the area of Drug Treatment Court and Youth Justice, which focus on treatment for youth *within* the criminal justice system (Government of Canada, 2018b). While the commitment of such funding appears to offer strong evidence towards supporting youth treatment, when looking at this amount within the context of the entire budget, this allocation represents merely 0.04% of the entire budget.

This point also circles back to the emphasis on the enforcement pillar, and the fact that if youth do use substances then the only support they would receive is within the criminal justice system, after they have already been criminalized for using substances. This provides the underlying assumption that youth who use substances will inevitably end up in the legal system, reaffirming that youth should not be engaging in any form of substance use altogether. This is in complete contradiction with the principles of the four-pillar approach, and the findings from both the surveys and key informant interviews, which reiterated the need for youth-specific approaches and interventions. The fact that youth are neglected from what is supposed to be a national substance use strategy to address substance use in Canada is highly problematic. The evidence related to the rates of youth substance use is clear, and thus policies and strategies aimed at addressing a national substance crisis must include conversations around youth. Without these discussions, youth are further stigmatized for using and placed in positions that do not offer tangible and appropriate solutions that can reduce the harms associated with use.

Overall, while the CDSS is a great strategy in theory, the lack of true integration of the four-pillar approach and the emphasis on the criminal justice lens is highly problematic. On the surface, the strategy explicitly narrates the integration of the four-pillars as a balanced approach to substance use. The WPR analysis revealed that the CDSS frames substance use as primarily an issue that requires a legal response. While the support of the four-pillar approach is widely recognized, the analysis of the CDSS exposes the Canadian Government's primary use of the 'enforcement pillar' as a way to respond to substance use issues- largely neglecting the other pillars. This heavily contradicts the evolving conceptualization of substance use, which attempts to move away from a criminalized framework.

In addition to these revelations, there are key gaps within the CDSS, which further make it a flawed strategy in its attempt to address substance use in Canada. Based on the language used in the strategy, the implicit understanding of substance use lends itself to the assumption that individual behaviours and decisions (operating outside any external factors such as the SDOH) dictate substance use. As a result of this embedded assumption, the solution to substance use issues are enforcement mechanisms through the reduction in use, crime, demand, and supply related to illicit substances. Furthermore, the lack of discussions around at-risk populations, and especially youth populations, implies that substance use is essentially an adult problem, and does not require a tailored approach to meet the specific needs of different populations, such as youth. This results in the strategy specifically advantaging some and disadvantaging others. More specifically, the ways in which substance use problems are represented exclusively disadvantages youth, who are the most vulnerable and require specific support and interventions that highlight harm reduction approaches.

As seen in the findings from both the survey and key informant interviews, harm reduction needs to be at the forefront of youth service provision in order to appropriately and effectively support youth who use substances. As such, not only does the strategy elucidate sentiments of substance use as a solely criminal issue, but the lack of harm reduction and youth-specific discussions disproportionately affect youth populations, and place them at a heightened risk of experiencing harms related to substance use.

Chapter 8: Discussion and Policy Implications

Based on the findings from the survey, the key informant interviews, and the WPR analysis, a number of interesting themes emerged: 1)The social determinants of health play a critical role in the reasons as to why substance use among youth may be initiated or maintained, and must be integrated into policy development; 2) Youth-appropriate and age-specific programs and policies are fundamental in responding to substance use issues among youth, such as harm reduction initiatives; and 3) The national CDSS intended to guide substance use policies provides a false sense of action, and incorrectly represents youth substance use issues while implicitly promoting a law and order-based framework. Discourse around substance use in Canada has been recently and increasingly characterized under a public health framework, whereby substance use is understood as a health issue as opposed to a criminal or moral problem. This notion has been further supported by the CDSS' national endorsement of the four-pillar policy approach to dealing with substance use issues in Canada, positioning prevention, treatment, harm-reduction and enforcement as pillars which can work comprehensively to effectively address substance use issues. However, policy guidelines within the CDSS which aimed to address a chronic and longstanding public health problem were overwhelmingly dominated by enforcement mechanisms, with a strong focus on a reduction in supply and demand and ultimately use, as opposed to treatment - and more importantly - harm reduction.

Further, the lack of inclusion of the SDOH undermined their integral relationship with substance use among youth, and supported the notion that substance use is principally an individual choice, that must be handled legally. Because of the positioning of the CDSS, the philosophy of substance use within the strategy is at odds with the tenets of the four-pillar approach.

Moreover, the experiences and perceptions provided by frontline workers revealed a systemic gap in the identified needs for youth service provision and the reality of service delivery. There has also been revelation regarding the absence of youth-specific substance use policies and programs in Canada which are critical in supporting youth, such as harm-reduction and age-appropriate services. Adolescents have their own specific needs which must be addressed in a particular way, and it is imperative to pay close attention to the variations in youth development and have tailored programs to meet the diverse needs of youth.

While there have been significant strides towards addressing substance use issues among youth, Canada as a country still has a long way to go. In order to adequately respond to substance use issues among youth, a specific youth strategy that accurately represents substance use as a public health issue, focuses on the SDOH, and highlights the variations in youth development, must be established. Tailored policies that underscore harm-reduction initiatives and take into account the evolving substance use patterns among youth that are often shaped by socio-political and geographic factors, should be developed and enforced. It is important for Canada to have a coordinated national response to youth substance use issues which will ultimately trickle down provincially, locally and be standardized within service provision across the country.

Integrating the Social Determinants of Health into Policy

Through the critical analysis of the SDOH, it is clear that social and economic factors shape behaviour and the health of those who use substances. Specific determinants such as early life, housing and neighborhood, social factors, and socio-economic status may both indirectly and directly, as well as independently and/or jointly, shape individual substance use behaviour (Galea

and Vlahov, 2002). As discussed in Chapter 4, a health equity approach to substance use looks at the societal causes of inequalities in health and how public policy aims to address these issues. While the recognition of the role SDOH play in substance use among youth is becoming more evident, services and policies do not always reflect these understandings. Much research has focused on the biomedical link between substance use and health outcomes, and increasingly on behavioural research, which looks at risk behaviour and health outcomes (Galea and Vlahov, 2002). While this approach recognizes that substance use moves beyond medical boundaries, it still fails to systemically acknowledge the SDOH and the related factors associated with use. Services and frontline providers must acknowledge the role the SDOH play in shaping risk factors for substance use, and integrate this philosophy within service provision. Social and economic factors affect health indirectly by shaping individual substance use behaviour and directly affect health by affecting the availability of resources (Galea and Vlahov, 2002). This understanding can work towards improving service provision at different levels which can help target the systemic issues related to youth use, by also improving access.

The WPR analysis also exposed the fact that the CDSS undermines the role of the SDOH. Not recognizing the fundamental role of SDOH in substance use causes grave inequities when supporting youth who use. The very nature of a federal strategy undermining and neglecting the role is telling of Canada's inequitable health system. Services are thus not being informed and guided appropriately towards responding to differing subpopulations of youth (e.g., vulnerable vs mainstream), who face different and distinct challenges related to the SDOH. The government essentially fails to take this into consideration the inverse relationship between substance use and related harms, and social conditions, which may be reflected in service provision. While many of

the service providers from the surveys and key informant interviews recognized the SDOH, it wasn't clear that all did, and how this understanding was incorporated within their services. Some identified how SDOH factors have triggered substance use among the youth that they serve, and understood the systemic reasons as to why youth initiated use in the first place, such as familial issues related to early-life. All frontline workers, regardless of which level of service provision they are working in, must be trained adequately to understand and recognize the relationship between the SDOH and substance use. Without this understanding, appropriate and meaningful care cannot be provided and achieved. Integrating the SDOH into policies would not only help address the underlying reasons why youth initiate and continue substance use, but also generate and develop ways in which services can appropriately respond to substance use issues youth may be facing.

Moreover, without the systemic understanding and integration of the SDOH into policies, legal and enforcement responses may grow, as there is no real understanding of why individuals are engaging in substance use to begin with. Overreliance on interventions that address the supply of substances without a balanced focus on the SDOH is clearly insufficient in addressing substance use related harms. Much research has supported the notion that cyclical involvement in the criminal justice system is likely if the social determinants of health are not addressed (CSC, 2000; Baciu et al., 2017). As such, the focus on enforcement and security mechanisms that the CDSS promotes and the undermining of the SDOH reinforces the potential for youth to get caught up in the criminal justice system. Failure to comprehend and recognize the systemic reasons for use may result in counterproductive responses that fails to address the issues at hand, and further supports enforcement and legal pillars. The integration of the SDOH in the CDSS can

help advance the improvement of substance use policies to promote SDOH inclusion in policy-making and service provision, and to expand policies to include a more comprehensive focus, besides simply prevention or enforcement. It is not to say that the recognition of the SDOH will help prevent substance use, or stop youth from using, instead, it allows for service providers to recognize the role of the SDOH and help to ensure youth are provided the best care possible by taking a more informed approach. If SDOH are included in guiding national frameworks and strategies, then this understanding will inevitably trickle into service development. Without this systemic conceptualization, services run the risk of being inappropriately developed and frontline providers being inadequately trained, thus potentially perpetuating the harms youth experience, or not effectively addressing the root of the problem.

Youth-Specific and Harm Reduction Responses

One of the major failures of substance use policy in Canada is that policies and programs tend to fit under a 'general' umbrella, lumping both youth and adults as well as other sub-populations together into programs that are not tailored to meet the needs and particular circumstances of those populations. Commonly, programs are adult-based, and where these are applied to youth, they may or may not be slightly amended to address specific youth needs. As this dissertation has shown, youth face distinct challenges and have specific needs that adult programs could not appropriately address. The needs of youth vary considerably from that of adult populations. In fact, even within the youth demographic, it is important to pay attention to the variations in youth development levels, as youth require different support and programs depending on where they are at within their general development as well as the substance use spectrum (Abuse, 2016a). The failure of the CDSS in not acknowledging or addressing youth substance use issues is in of

itself an extreme shortfall. There is a desperate need for a genuine commitment to evidence-based practice and policy which work towards supporting youth who have substance use issues. Specifically, in relation to the four-pillar framework, the harm-reduction pillar has primarily served as a critical approach in responding to substance use issues in Canada. Frontline workers who participated in this study recognized the importance of both non-pharmacological and prevention interventions in supporting youth, and also stated that many of the youth services in fact do offer these interventions. Examples of non-pharmacological and prevention interventions include education, counselling, and cognitive behavioural therapy (CBT). These types of interventions focus on and address both the prevention of substance use, as well as target the early stages of use among youth. Additionally, non-pharmacological interventions are also similar to harm reduction approaches as they both recognize the psychological and social aspects which contribute to use, as opposed to a strictly biological basis and related clinical treatment options (Logan and Marlatt, 2010). In this way, non-pharmacological interventions attempt to address the root causes of use and provide comprehensive support which is intended to reduce the harms associated with use, while recognizing that youth will probably continue to use (Logan and Marlatt, 2010). However, despite the identification of these services as being currently offered, there continues to be a great need for additional harm reduction and prevention services to work in support of youth who engage in substance use, as expressed by the majority of participants in my study (Jenkins et al., 2017).

Evidence has supported the notion that policies and services that focus on these pillars will be most effective when working with youth as it provides a different level of service support that youth desperately need, using non-judgemental and non-abstinence based frameworks (Logan

and Marlatt, 2010). While the services identified by the participants may have overlapped between prevention and harm reduction, such as education, counselling, self-help groups etc., there continues to be acknowledgement for the need for more of these services, especially when working with a youth demographic. Interestingly, individual counselling, relapse prevention, and harm reduction were among the top three services identified as being offered within these youth services. While there is identification of these imperative services, the participants still spoke to the need for more, in particular, the need for family counselling, perhaps recognizing the need for parental involvement as an effective and appropriate approach.

Moving in the Right Direction

While there is a lack of true integration of the four-pillars philosophy and a misrepresentation of substance use in the CDSS, it is not to say that the government and substance use organizations are not moving in the right direction. Harm reduction and prevention approaches are popular among the discourse, and given their recognition, they have gained positive momentum in the integration and philosophy of many services. With the new Federal government bringing back harm reduction pillars into the national substance strategy and publicly endorsing and providing support for these pillars, Canada is continuously changing the discourse around substance use. The fact that these pillars are endorsed and at the forefront of the CDSS is an affirmative step forward - even though they may not be tangibly enforced and genuinely integrated.

This integration can also be seen from the findings from the study. Prevention and harm reduction were emphasized by participants as central components to youth substance use services. Many of the participants identified using these principles in the ways in which their

service or program operates. This is an indication that the pillars are at times being integrated on the ground, guiding the design and execution of beneficial interventions needed to address substance use among youth. In fact, only 6% (n=3) of participants whom participated in the online survey identified that their organization did not offer harm reduction services. This is a positive suggestion that many of these youth programs recognize the importance and value of harm reduction philosophies in youth service provision. However, when examining the CDSS there is clearly a gap in clear policy direction and representation of the pillars to support these efforts, which can be attributed to why the ways in which services are offered vary considerably and inconsistently. As such, there is clearly a long way to go to improve policy and service development for youth in Canada. In the next section, I offer policy recommendations on ways to reduce the identified gaps between the ways in which substance use in the CDSS is represented compared to reality, and propose strategies to encourage policy makers to develop youth-friendly substance use policies and programs.

Future Directions

In order to genuinely work towards addressing this longstanding public health issue, first and foremost, a national youth-specific strategy must be developed. This strategy must include the following: a) recognition of the SDOH and the vital role they play in shaping substance use behaviours; b) must focus on evidence-based youth oriented practices, such as harm reduction and prevention initiatives, including non-pharmacological and specific treatment interventions; and c) must engage with youth in the development of services, and be cautious of the varying substance use patterns developed by youth (both mainstream and marginalized) in different geographical and social contexts.

The Canadian government must develop a youth-specific strategy to support youth who use substances, if they are genuinely committed to addressing substance use issues among this demographic. The implicit understanding that substance use issues are largely an adult problem and do not require a specific focus on youth or the SDOH, as implicitly proposed in the CDSS, is disappointing to say the least. The overwhelmingly large focus on enforcement mechanisms need to be reduced in the inclusion of such strategy, as the criminal justice system is not an appropriate response to substance use generally, and especially among youth as it can lead to a lifetime of legal and other problems. It is time to change how national documents address and view substance use issues, moving away from a criminalized response to a harm-reduction and public health framework. There needs to be a reform in the ways in which substance use issues and service provision are perceived and implemented, and health care organizations and agencies need to be at the forefront of this change.

Adolescence is the period of time in which most substance use is initiated, and when patterns of use can be most harmful both in terms of the developing brain and life course outcomes and trajectories (Jordan and Andersen, 2017). These patterns are impacted by the SDOH, including social, political and geographical contexts, as youth substance use behaviours are often times dependent on their broader social context, related to where they live and the patterns of substance use in their area (Jenkins et al., 2017). Due to variations in experiences and the SDOH, youth needs are very different from those of adults, and thus require different programs and treatment options as a response. As such, youth require a different level of service provision and support, and there is not a one-size fits all approach that can be effective for all substance users. Youth face distinct challenges and demand different levels of support depending on where they are on

the substance use spectrum. That is why harm-reduction initiatives are highly favored in the context of youth substance use, as it avoids taking a uniform stance that substance use is bad, it meets the youth where they are 'at' in terms of their use, and it works to help support users on how to minimize their risks associated with use (Erickson et al., 2002).

While the four-pillars approach is a reputable and recognized approach to deal with substance use issues among the general population, certain pillars need to be adopted more widely for youth. For instance, the participants identified that education promotion – including about the potential harms of use - for both youth and families is critical in supporting youth with their substance use. Participants also acknowledged the need for health promotion services to be more widely integrated into places where youth have direct access to, such as integrating into school-based programs. This approach may not be as appropriate or relevant for the general adult user population. Furthermore, there is strong evidence for the effectiveness of family-based programming for substance use prevention and harm reduction for youth. In fact, 26% (n=14) of service providers whom participated in the survey identified family counselling as an effective intervention that they would like their service to offer. There are many evidence-based family programs and models that have been adopted to help youth with their substance use, primarily focusing on the prevention-pillar and working towards reducing the stigma associated with use from families, which was noted as a barrier for youth to access treatment. For instance, programs such as *Family Matters*- a prevention program designed to prevent tobacco and alcohol use in children between the ages of 12 to 14 years; the *Brief Strategic Family Therapy,* a family-based prevention program which aims to decrease individual and family risk factors, and targets delinquent as well as substance using youth (Griffin et al., 2010). *Multidimensional Family*

Therapy is an outpatient, family-based treatment program developed for adolescents with substance use, whereby treatment focuses on individual characteristics of the youth, the parents and other key individuals in the youth's life, in addition to determinants contributing to the initiation and use of substances by the youth (Austin et al., 2005). All these programs, while implemented primarily in the United States, have been positively evaluated. More specifically, *Creating Lasting Family Connections (CLFC)* is a family focused program aimed at increasing parenting skills and family relations to build the resiliency of youths aged 9-17 years, and to increase knowledge about alcohol and substance use as a prevention initiative to reduce the frequency of use (Strader et al., 2018). To prove its effectiveness, two independent peer-reviewed outcome papers reported the findings of one cohort of youth and parents who used this program. In comparison to youth who did not use the CLFC intervention, those receiving the CLFC intervention reported less frequent alcohol use in the previous three-month period. Additionally, CLFC reduced the frequency of substance consumption at the 12-month assessment. In addition to the reduced frequency of substance use, the findings indicated other positive outcomes such as increased use of other community-related services as well as parental education and perceptions on substance use (Griffin and Botvin, 2010). As such, this program is an example of an approach that would specifically be beneficial for youth, as a prevention exercise working with youth and families to provide substance education to parents and youth, build coping mechanisms to resist negative social influences for youth and delay the onset and reduce the frequency of substance use among participating youth. If services systematically offered family-based programming for youth, there would be opportunities to reduce both negative outcomes associated with use, as well reduce the stigmatization of substance use from family perceptions and work towards creating a more inclusive and informed environment.

Additionally, the findings from the survey and key informant interviews identified a desperate need for the expansion to effective, evidence-based treatments, such as detoxification services for youth. The lack of detoxification treatment services available to youth has been deemed extremely problematic, as it is something that youth require, however are often unable to access as the programs have specific age requirements that disqualify youth from attending. In fact, the main concern that was discussed regarding detoxification services across all key informants was that there was no youth-specific detoxification service. This provides the impression that withdrawal management and detoxification services are intended solely for adult populations, dismissing the understanding that some youth would need to access such service. Participants illustrated how detoxification services were attributed to a lot of stigma, and was thus something that would perhaps be frowned upon when discussed. However, a specific youth strategy can look at the findings from this study, and see where service provision for youth can be improved, and which services would benefit youth, making note of detoxification programs and further supporting the treatment pillar. This further reinforces the importance of having a strategy or policy which focuses specifically on youth, ensuring that all factors are being considered, including where they are at in the substance use spectrum, and recognizing the social, cultural and economic forces which contribute to youth substance use, as well as the various barriers they uniquely face.

Furthermore, as noted in previous chapters, substance use patterns and choices among youth are different than that of general user populations. The findings have suggested that cannabis and alcohol are the top two frequently reported substances used by youth who access their services. As such, specific responses to these substances would be very different than responses to illicit

substances such as opioids or other stimulants. The need for a federal and/or provincial strategy which documents the frequently used substances by youth, as well as effective approaches in responding to use would be extremely helpful and advantageous. In fact, the findings from the surveys further reinforced the need for non-pharmacological, prevention, harm-reduction interventions, as well as knowledge exchange products as an effective response to working with youth who frequently use cannabis or alcohol. While these interventions would differ based on geographical and social context, a uniformed framework in addressing such issues would help target a large percentage of youth who primarily use these substances, or use them as a gateway to other substances.

A strategy must also encompass all aspects of youth-specific substance use, including the factors that contribute to initiation or use continuation (such as the SDOH and their environment) as well as the specific stigma and barriers to service access they may face, which are unique from those related to adults. As an example, youth face distinct barriers in accessing certain services, whether that be lack of family/peer support, inability to access services, stigmatization, physical barriers such as transportation, etc., and this could also be related to their geographical location, and the lack of resource allocation or community support. In fact, 65% (n=35) of participants illustrated how stigmatization was recognized as a huge barrier in addressing substance use issues and promoting youth to seek services. The stigma youth face is different than the experiences faced by adult or other populations. Since substance use generally is framed as an 'adult' problem, as seen through the WPR analysis, stigma against youth users is amplified, and further discourages youth from feeling as though it is acceptable to seek help when they are in need. This creates additional challenges in ensuring youth are able to access the services they

need, when they need them, and often times can act as a deterrent in seeking support. This stigma can also be related to specific substances and can be dependent on the geographic location. For instance, the normalization of licit substances such as cannabis and alcohol may contribute to whether or not youth perceive these substances as harmful, and ultimately affect their use and recognition of potential harms and help-seeking behaviour. Variations in normalization and acceptability of particular substances also occur and may influence use and outcomes (e.g., substances may be normalized in one geographic region or social circle, but not another). While the 2020 PHAC *Primer to Reduce Substance Use Stigma in the Canadian Health System* has helped to change the language and perceptions around substance use generally, it still fails to acknowledge youth and the stigmatization that impact youth from accessing necessary services. It is important to integrate discussions around youth into those pivotal conversations, as substance use is not an adult problem and it is essential to understand the different ways youth stigma can be addressed. A youth-specific policy would inevitably help break down the barriers associated with youth substance use, and work towards changing public rhetoric and misrepresentations of use among this demographic.

The findings from the key informant interviews suggested that in order to reduce the stigmatization associated with accessing services, structural barriers need to be addressed, such as age of consent and eligibility issues, wait-times, etc. Youth services should thus be developed in a way that ensures that accessing the service is as easy as possible, negating any potential barriers, and not being entirely dependent on the support and facilitation of a parent/guardian. Furthermore, ensuring that substance use services are not disconnected from other health

services, and are available in areas where youth can readily access them, such as schools and afterschool/extra-curricular programs, would help towards reducing substance use stigma. Relatedly, in order to truly address the issues related to barriers experienced and the implementation and accessibility of services, it is critical for youth to be engaged in decision-making processes. At the macro level, it is important to mobilize youth to consult and engage in the development of a national youth strategy that takes into account the various challenges and needs youth require. It is fundamental for youth approaches and policies to be informed by youth voices or studies that focus on those with lived experience working with youth, such as this dissertation, to ensure that approaches are implemented that are both appropriate, practical and resonate with youth.

Since substance use patterns vary based on SDOH, and geographical context, it is imperative for local service providers to have guidance on how to implement programs that are most applicable for the youth that they serve. Researchers have found links between engagement and several different positive health outcomes related to substance use, including decreased alcohol and cannabis use (Brownlie et al., 2017). Meaningful engagement at the national policy level will result in meaningful engagement at the local service provision level which will ensure that the programs that are being offered are most effective and useful for the youth demographic in that area. As an example, if a community has a high rate of alcohol use, but instead implements a program directed at opioids or other illicit substances, then evidently service provision in that community will not address the substance issues related to the community. As such, communities and services need to tailor their programs to the individual needs of the youth, as well as the general community-based substance use trends.

There are some examples of Canadian programs that are aligned with the harm-reduction model and understand the importance of the integration of the SDOH and youth-specific approaches. For instance, the Youth Wellness Hubs Ontario (YWHO) is an initiative built on similar evidence-informed initiatives that are underway in different parts of Canada, such as British Columbia (Youth Wellness Hubs Ontario, 2020). The purpose of this intervention aims to bring the appropriate services to youth, and their families-where appropriate-at the right time and in the right place, and to ultimately address gaps in youth service provision in Ontario. There are ten hubs in Ontario for youth between the ages of 12-25 to address a variety of their needs, including mental health and substance use (Youth Wellness Hubs Ontario, 2020). Funded by the Ontario Government in 2017, the hubs aim to provide rapid access to substance use and mental health services, with low-barrier access; provide evidence-based interventions which match the specific needs of the youth; co-creating services with families and youth; and act as a one-stop-shop model of care for youth support services. Imperative to this service, is the critical engagement of youth and families in key decisions, from planning to implementation (Youth Wellness Hubs Ontario, 2020). While this model is currently undergoing an evaluation to identify its effectiveness, it is clear that their harm-reduction approach, coupled with youth specific programs and services- including substance specific programs- and involvement of youth in decision-making process is a significant step forward in advancing youth service provision in Ontario.

In conclusion, since policy changes are often driven by research, it is my hope that this dissertation sheds light on the tensions between policy and practice, and the ways in which the provincial and federal government of Ontario can create policies that are appropriate and

effective, taking into consideration the lived experience of frontline service providers. Without these perspectives, policy-making will continue to be top-down, and guided by individuals who do not accurately understand the realities on the ground. Until there is a specific strategy put in place that works directly in support of youth – and in the ways, that they need it the most – youth substance use issues will continue to remain unaddressed. This means no more shelved reports and lip-service, and real policy change that will translate into better health outcomes for a growing and vulnerable youth population.

References

Abuse, S., US, M. H. S. A., & Office of the Surgeon General (US. (2016a). VISION FOR THE FUTURE: A PUBLIC HEALTH APPROACH. In *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet]*. US Department of Health and Human Services.

Abuse, S., US, M. H. S. A., & Office of the Surgeon General (US. (2016b). Early intervention, treatment, and management of substance use disorders. In *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet]*. US Department of Health and Human Services.

Abuse, S. (2016c). Treatment Episode Data Set (TEDS): 2004–2014. National admissions to substance abuse treatment services. In *Center for Behavioral Health Statistics and Quality, BHSIS series S-84, HHS publication no.(SMA) 16-4986*. Substance Abuse and Mental Health Services Administration, Rockville, MD.

Adair, C. E. (2009). *Concurrent substance use and mental disorders in adolescents: a review of the literature on current science and practice*. Alberta Centre for Child, Family and Community Research.

Adler, N. E., Boyce, T., Chesney, M. A., Cohen, S., Folkman, S., Kahn, R. L., & Syme, S. L. (1994). Socioeconomic status and health: the challenge of the gradient. *American psychologist*, *49*(1), 15.

Age limits and adolescents. (2003). Paediatrics & child health, 8(9), 577–578.

Ahumada, G., Araneda, J. C., Clarke, P., Cumsille, F., & Hynes, M. (2019). *Reporting on Drug Use in The Americas 2019*. Retrieved from: http://www.cicad.oas.org/oid/Report%20on%20Drug%20Use%20in%20the%20Americas%202019.pdf

Allan, B. & Smylie, J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute.

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: a framework for health professionals. *Cmaj*, *188*(17-18), E474-E483.

Anderson, T., Swan, H., & Lane, D. C. (2010). Institutional fads and the medicalization of drug addiction. *Sociology Compass*, *4*(7), 476-494.

Andrews, J. A., Hops, H., Ary, D., Tildesley, E., & Harris, J. (1993). Parental influence on early adolescent substance use: Specific and nonspecific effects. *The Journal of Early Adolescence*, *13*(3), 285-310.

Anthony, J. C., Warner, L. A., & Kessler, R. C. (1997). Comparative epidemiology of

dependence on tobacco, alcohol, controlled substances, and inhalants: basic findings from the National Comorbidity Survey.

Armstrong, T. D., & Costello, E. J. (2002). Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. *Journal of consulting and clinical psychology*, *70*(6), 1224

Ashford, R. D., Brown, A. M., & Curtis, B. (2019). "Abusing addiction": Our language still isn't good enough. *Alcoholism treatment quarterly*, *37*(2), 257-272.

Assari, S., Mistry, R., Lee, D. B., Caldwell, C. H., & Zimmerman, M. A. (2019). Perceived racial discrimination and marijuana use a decade later; gender differences among black youth. *Frontiers in Pediatrics*, *7*, 78.

Austin, A. M., Macgowan, M. J., & Wagner, E. F. (2005). Effective family-based interventions for adolescents with substance use problems: A systematic review. *Research on social work practice*, *15*(2), 67-83.

Bacchi, C. (2009). Analysing Policy: Whats the problem represented to be. *Frenchs Forest*.

Bacchi, C. (2012a). Introducing the 'What's the problem represented to be? Approach. *Engaging with Carol Bacchi: Strategic interventions and exchanges*, 21-24

Bacchi, C. (2012b). Why study problematizations? Making politics visible. *Open journal of political science*, *2*(01), 1.

Bacchi, C. (2016). Problematizations in health policy: Questioning how "problems" are constituted in policies. *Sage Open*, *6*(2), 2158244016653986.

Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (2017). Communities in action: pathways to health equity.

Backes, E. P., & Bonnie, R. J. (2019). The Promise of Adolescence: Realizing Opportunity for All Youth.

Beasley, C., & Bletsas, A. (2012). *Engaging with Carol Bacchi. Strategic Interventions and Exchanges* (p. 168). University of Adelaide Press.

Becker, J. B., McClellan, M. L., & Reed, B. G. (2017). Sex differences, gender and addiction. *Journal of neuroscience research*, *95*(1-2), 136-147.

Belzak, L., & Halverson, J (2018). The opioid crisis in Canada: a national perspective. *Health promotion and chronic disease prevention in Canada: research, policy and practice 38(6), 224-233*

Bian, H. (2015). Mixed methods research. *Retrieved from*.

Blaxter, M. (2010). *Health* (2nd ed.). Cambridge UK: Polity Press.

Boak, A., Elton-Marshall, T., Mann, R. E., & Hamilton, H. A. (2020). Drug use among Ontario students, 1977-2019: Detailed findings from the Ontario Student Drug Use and Health Survey (OSDUHS). Toronto, ON: Centre for Addiction and Mental Health. Retrieved from: https://www.camh.ca/-/media/files/pdf---osduhs/drugusereport_2019osduhs-pdf

Boardman, J. D., & Saint Onge, J. M. (2005). Neighborhoods and adolescent development. *Children, Youth and Environments*, *15*(1), 138.

Booth, J. M., & Anthony, E. K. (2015). Examining the interaction of daily hassles across ecological domains on substance use and delinquency among low-income adolescents of color. Journal of Human Behavior in the Social Environment, 25, 810-821.

Borrell, L. N., Jacobs, D. R., Williams, D. R., Pletcher, M. J., Houston, T. K., Kiefe, C. I. (2007). Self-reported racial discrimination and substance use in the Coronary Artery Risk Development in Adults study. American Journal of Epidemiology, 166, 1068-1079.

Botticelli, M. P., & Koh, H. K. (2016). Changing the language of addiction. *Jama*, *316*(13), 1361-1362.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Boyd, S., & MacPherson, D. (2018). Community Engagement-The Harms of Drug Prohibition: Ongoing Resistance in Vancouver's Downtown Eastside. *BC Studies: The British Columbian Quarterly*, (200), 87-96.

Boyd, N. (2013). Lessons from INSITE, Vancouver's supervised injection facility: 2003–2012. *Drugs: education, prevention and policy*, *20*(3), 234-240.

Braveman, P., & Gottlieb, L. (2014). The social determinants of health: it's time to consider the causes of the causes. *Public health reports*, *129*(1_suppl2), 19-31.

Braveman, P., & Gruskin, S. (2003). Defining equity in health. Journal of epidemiology and community health, 57(4), 254-258.

British Columbia Coroners Service. (2020*). Illicit Drug Toxicity Deaths in BC January 1, 2010 – May 31, 2020*. Retrieved June 1, 2020, from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

Broyles, L. M., Binswanger, I. A., Jenkins, J. A., Finnell, D. S., Faseru, B., Cavaiola, A., ... & Gordon, A. J. (2014). Confronting inadvertent stigma and pejorative language in addiction scholarship: a recognition and response.

Brown, S.M., & Shillington, A.M. (2016). Childhood adversity and the risk of substance use

and delinquency: The role of protective adult relationships. *Child Abuse & Neglect, 63*, 211-221.

Brownlie, E. B., Chaim, G., Heffernan, O., Herzog, T., & Henderson, J. (2017). Youth services system review: Moving from knowledge gathering to implementation through collaboration, youth engagement, and exploring local community needs. *Canadian Journal of Community Mental Health*, *36*(Special Issue), 133-149.

Bryman, A. (2001) *Social Research Methods.*Oxford: University Press.

Cambron, C., Kosterman, R., Rhew, I.C., Catalano, R.F., Guttmannova, K., Hawkins, J.D. (2019). Neighborhood Structural Factors and Proximal Risk for Youth Substance Use. *Prevention science: the official journal of the Society for Prevention Research.*

Canada (Attorney General) *v.* PHS Community Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134

Canadian Centre on Substance Use and Addiction (CCSA). (2020). *Changes related to COVID-19 in the illegal drug supply and access to services, and resulting health harms.* Retrieved from: https://www.ccsa.ca/sites/default/files/2020-05/CCSA-COVID-19-CCENDU-Illegal-Drug-Supply-Alert-2020-en.pdf

Canadian Centre on Substance Abuse. (2013). *Why Mental Health and Substance Abuse Problems Collide: Understanding, preventing, identifying and addressing mental health disorders and substance abuse issues in youth.* Retrieved from: https://www.ccsa.ca/sites/default/files/2019-05/CCSA-Mental-Health-and-Substance-Abuse-2013-en.pdf

Canadian Centre on Substance Abuse. (2007). Substance Abuse in Canada: Youth in Focus. Ottawa, ON: Canadian Centre on Substance Abuse. Retrieved from: https://www.ccsa.ca/sites/default/files/2019-04/ccsa-011521-2007-e.pdf

CBC News. (2020 November). *Vancouver unanimously approves motion to seek decriminalization of drug possession*. Retrieved from: https://www.cbc.ca/news/canada/british-columbia/bc-vancouver-drug-decriminalization-vote-1.5816980

CBC News. (2019 November). *Ontario starts merging health agencies, fires 9 LHIN executives.* The Canadian Press. Retrieved from: https://www.cbc.ca/news/canada/toronto/ontario-merges-health-agencies-1.5357797

Centers for Disease Control and Prevention. (2006). Youth risk behavior surveillance—United States, 2005. Morbidity and Mortality Weekly Report, 55, No. SS-5.

Center for Substance Abuse Treatment. (2012). Managing chronic pain in adults with or in recovery from substance use disorders.

Chen, P., & Jacobson, K. C. (2012). Developmental trajectories of substance use from early adolescence to young adulthood: Gender and racial/ethnic differences. *Journal of Adolesence Health, 50* (2), 154-163.

City of Toronto. (2020a). Toronto Overdose System. Toronto, Ontario: City of Toronto. Retrieved from: https://www.toronto.ca/community-people/health-wellness-care/health-inspections-monitoring/toronto-overdose-information-system/

City of Toronto. (2020b). Continuum of Use. Toronto, Ontario. Retrieved from: https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/overdose-prevention-and-response/get-support/continuum-of-use-2/

Commission on Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the commission on social determinants of health*. World Health Organization.

Community Drug Strategy for Strathcona County. 2019. *From Addiction to Connection*. Alberta, Canada: Community Drug Strategy for Strathcona County. Retrieved from: https://www.strathcona.ca/files/files/fcs-comdrugstrategy-final.pdf

ConnexOntario. 2020. ConnexOntario discover mental health, addiction and problem gambling services. Ministry of Ontario. Retrieved from: https://www.connexontario.ca/en-ca/our-services

Correctional Service of Canada (CSC) (2000). "Myths and Realities: How Federal Corrections Contributes to Public Safety," 2nd ed. Available online at: http://www.cscscc.gc.ca/text/pubed/mr/mr-e.pdf

Creswell, J. W., Plano Clark, V. L., Gutmann, M. L., & Hanson, W. E. (2003). Advanced mixed methods research designs. *Handbook of mixed methods in social and behavioral research*, *209*, 240.

Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage publications.

Creswell, J. W. (2013). Steps in conducting a scholarly mixed methods study

Creswell, J., & Wisdom, J. (2013). Mixed Methods: Integrating quantitative and qualitative data collection and analysis while studying patient-centered medical home models. *Lincoln: University of Nebraska*.

D'Mello. (2020). Ontario postpones part of its health care overhaul due to COVID-19. CTV News. Toronto, Ontario. Retrieved from: https://toronto.ctvnews.ca/ontario-postpones-part-of-its-health-care-overhaul-due-to-covid-19-1.4858008

Degenhardt, L., Stockings, E., Patton, G., Hall, W. D., & Lynskey, M. (2016). The increasing global health priority of substance use in young people. The lancet. Psychiatry, 3(3), 251–264. https://doi.org/10.1016/S2215-0366(15)00508-8

Dixon, J. (2000). Social determinants of health. *Health Promotion International, 15*(1), 87-89.

Dumbili, E. W. (2014). Use of mixed methods designs in substance research: a methodological necessity in Nigeria. *Quality & Quantity*, *48*(5), 2841-2857.

Elton-Marshall, T., Leatherdale, S. T., & Burkhalter, R. (2011). Tobacco, alcohol and illicit drug use among Aboriginal youth living off-reserve: results from the Youth Smoking Survey. *Cmaj*, *183*(8), E480-E486.

Erickson et. al. (2002) Center for Addiction and Mental Health and Harm Reduction. A Background Paper on its Meaning and Application for Substance use Issues. Retrieved from: http://www.camh.ca/en/hospital/about_camh/influencing_public_policy/public_policy_submissions/harm

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research*, *12*(4), 531-545.

Galea, S., & Vlahov, d. (2002). Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public health reports (Washington, D.C.: 1974), 117 Suppl 1* (Suppl 1), S135-S145

Garcia, R. A., Kenyon, K. H., Brolan, C. E., Coughlin, J., & Guedes, D. D. (2019). Court as a health intervention to advance Canada's achievement of the sustainable development goals: a multi-pronged analysis of Vancouver's downtown community court. *Globalization and health*, *15*(1), 1-14.

Gee, G. C., & Ford, C. L. (2011). STRUCTURAL RACISM AND HEALTH INEQUITIES: Old Issues, New Directions1. *Du Bois review: social science research on race*, *8*(1), 115.

Gibbons, F. X., Gerrard, M., Cleveland, M. J., Wills, T. A., & Brody, G. (2004). Perceived Discrimination and substance use in African American parents and their children: A panel study. *Journal of Personality and Social Psychology*, **86**, 517– 529.

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909

Gould, T. J. (2010). Addiction and cognition. *Addiction science & clinical practice*, *5*(2), 4.

Government of Canada. (2020). Emergency Treatment Fund. Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/responding-canada-opioid-crisis/emergency-treatment-fund.html

Government of Canada, (2019a). Summary of results for the Canadian Student Tobacco, Alcohol and Drugs Survey 2018-19. Retrieved from: https://www.canada.ca/en/health-canada/services/canadian-student-tobacco-alcohol-drugs-survey/2018-2019-summary.html

Government of Canada. (2019b). *The Chief Public Health Officer's Report on The State of Public Health in Canada 2018: Preventing Substance Use in Youth*. Retrieved from: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth/2018-preventing-problematic-substance-use-youth.pdf

Government of Canada. (2019c). *Canadian Tobacco, Alcohol and Drug Survey (CTADS): Summary of results for 2017*. Retrieved from: https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary.html

Government of Canada. (2019d). *Cannabis Legalization and Regulation*. Department of Justice. Retrieved from: https://www.justice.gc.ca/eng/cj-jp/cannabis/

Government of Canada. (2019e). *About the Good Samaritan Drug Overdose Act.* Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/about-good-samaritan-drug-overdose-act.html

Government of Canada. (2018a). Strengthening Canada's Approach to Substance Use Issues. Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy/strengthening-canada-approach-substance-use-issue.html

Government of Canada. (2018b). *Supplementary Information Tables 2018-19 Departmental Plan: Health Canada.* Government of Canada. Retrieved from: https://www.canada.ca/en/health-canada/corporate/transparency/corporate-management-reporting/report-plans-priorities/2018-2019-supplemental-information-tables.html#a4a

Government of Canada. (2017) *Canadian drugs and substances strategy.* Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/canadian-drugs-substances-strategy.html

Gracey, M., & King, M. (2009). Indigenous health part 1: determinants and disease patterns. *The Lancet*, *374*(9683), 65-75.

Greenwood, M. L., & de Leeuw, S. N. (2012). Social determinants of health and the future well-being of Aboriginal children in Canada. *Paediatrics & child health*, *17*(7), 381-384.

Greer, A. M., Luchenski, S. A., Amlani, A. A., Lacroix, K., Burmeister, C., & Buxton, J. A. (2016). Peer engagement in harm reduction strategies and services: a critical case study and evaluation framework from British Columbia, Canada. *BMC Public Health*, *16*(1), 452.

Grella, C. E., Hser, Y. I., Joshi, V., & Rounds-Bryant, J. (2001). Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. *The Journal of nervous and mental disease*, *189*(6), 384-392.

Griffin, K. W., & Botvin, G. J. (2010). Evidence-based interventions for preventing substance use disorders in adolescents. *Child and adolescent psychiatric clinics of North America*, *19*(3), 505–526. https://doi.org/10.1016/j.chc.2010.03.005

Guthrie, B. J., Young, A. M., Williams, D. R., Boyd, C. J., & Kintner, E. K. (2002). African American girls' smoking habits and day-to-day experiences with racial discrimination. *Nursing Research*, **51**, 183– 190.

Hasin, D. S., O'Brien, C. P., Auriacombe, M., Borges, G., Bucholz, K., Budney, A., ... & Schuckit, M. (2013). DSM-5 criteria for substance use disorders: recommendations and rationale. *American Journal of Psychiatry*, *170*(8), 834-851.

Health Canada. (2020). Opioid-related harms in Canada. Retrieved from: https://health-infobase.canada.ca/substance-related-harms/opioids/

Henderson, J., Chaim, G., & Brownlie, E. B. (2000). *Youth services system review: a review of the continuum of Ontario services addressing substance use available to youth age 12-24*. Centre for Addiction and Mental Health.

Herie, M., Godden, T., Shenfeld, J., & Kelly, C. (2010). Addiction: An information guide. Retrieved from: https://www.camh.ca/-/media/files/guides-and-publications/addiction-guide-en.pdf?la=en&hash=F1BFB1ED194D54A9FCF892116BFE745818169A56

Hill, D.M. (2009). Traditional medicine and restoration of wellness strategies. Journal of Aboriginal Health, 5(1), 26-42.

Hopkins, C., & Dumont, J. (2010). *Cultural Healing Practice Within National Native Alcohol and Drug Abuse Program-Youth Solvent Addiction Program Services*. National Native Alcohol and Drug Abuse Program.

Hostetter, M., & Klein, S. (2018). In Focus: Reducing Racial Disparities in Health Care by Confronting Racism.

Howe, Kenneth R. 1988. Against the quantitative-qualitative incompatibility thesis or dogmas die hard. Educational Researcher 17: 10–16

Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isle, L., Elliott, R., Pauly, B., ... & Hathaway, A. (2017). Harm reduction in name, but not substance: a comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm reduction journal*, *14*(1), 50.

Jaycox, L.H., Morral, A.R., Juvonen, J. (2003). Mental health and medical problems and service

use among adolescent substance users. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(6), 701-9.

Jenkins, E. K., Slemon, A., & Haines-Saah, R. J. (2017). Developing harm reduction in the context of youth substance use: insights from a multi-site qualitative analysis of young people's harm minimization strategies. *Harm reduction journal*, *14*(1), 53

Johnston, L. D., Miech, R. A., O'Malley, P. M., Bachman, J. E., & Patrick, M. E. (2020). Monitoring the Future National Survey Results on Drug Use, 1975-2019: Overview, Key Findings on Adolescent Drug Use. *Institute for Social Research*.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2007). *Monitoring the future national results on adolescent drug use: Overview of key findings, 2006* (NIH Publication No. 07-6202). Bethesda, MD: National Institute on Drug Abuse.

Jongbloed, K., Pearce, M. E., Pooyak, S., Zamar, D., Thomas, V., Demerais, L., ... & Yoshida, E. M. (2017). The Cedar Project: mortality among young Indigenous people who use drugs in British Columbia. *CMAJ*, *189*(44), E1352-E1359.

Jordan, C. J., & Andersen, S. L. (2017). Sensitive periods of substance abuse: Early risk for the transition to dependence. *Developmental cognitive neuroscience*, *25*, 29-44

Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, substance use disorders, and policy: the need to reach consensus on an "addiction-ary". *Alcoholism Treatment Quarterly*, *34*(1), 116-123

Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: past, present, and future. *Harm reduction journal*, *14*(1), 1-9.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 617-627.

Khoury, L., Tang, Y. L., Bradley, B., Cubells, J. F., & Ressler, K. J. (2010). Substance use, childhood traumatic experience, and posttraumatic stress disorder in an urban civilian population. *Depression and anxiety*, *27*(12), 1077-1086.

Kippin, T. E., Fuchs, R. A., Mehta, R. H., Case, J. M., Parker, M. P., Bimonte-Nelson, H. A., & See, R. E. (2005). Potentiation of cocaine-primed reinstatement of drug seeking in female rats during estrus. *Psychopharmacology*, *182*(2), 245-252.

Kirst, M., & Erikson, P. (2013). Substance use and mental health problems among street-Involved youth: The need for a harm reduction approach. *Youth homelessness in Canada: Implications for policy and practice*, 185-198.

Kisling, L. A., & Das, J. M. (2019). Prevention Strategies.

Knopf, T. (2019 January). *Switzerland couldn't stop drug users. So it started supporting them*. North Carolina Health News. Retrieved from: https://www.northcarolinahealthnews.org/2019/01/21/switzerland-couldnt-stop-drug-users-so-it-started-supporting-them/

Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: from theory to practice. *Social work in public health*, *28*(3-4), 194-205.

Leatherdale, S.T., Burkhalter, R. (2012). The substance use profile of Canadian youth: Exploring the prevalence of alcohol, drug and tobacco use by gender and age. *Addictive Behaviors, 37*(3), 318-322.

Leslie, K. M., Canadian Paediatric Society, & Adolescent Health Committee. (2008). Harm reduction: An approach to reducing risky health behaviours in adolescents. *Paediatrics & child health*, *13*(1), 53-56.

Lettner, M. (2008). *Health equity now: a working paper on the best first steps for Ontario*. Wellesley Institute.

Little, S. (2008). *Vancouver to ask feds to decriminalize drug possession within city Boundaries*. Global News. Retrieved from: https://globalnews.ca/news/7485084/vancouver-decriminalization-overdose/

Logan, D. E., & Marlatt, G. A. (2010). Harm reduction therapy: a practice-friendly review of research. *Journal of clinical psychology*, *66*(2), 201-214.

Lynch, J. (2000). Income inequality and health: expanding the debate. Social Science & Medicine, 51(7), 1001-1005.

Macdonald, A. (2011). Insite or Outside the Law: Examining the place of safe injection sites within the Canadian legal system. *Oñati Socio-Legal Series*, *1*(1).

MacPherson, D., & Rowley, M. L. (2014). *A framework for action: A four-pillar approach to drug problems in Vancouver: Prevention, treatment, enforcement, harm reduction*. City of Vancouver.

MacPherson, D. (2000). A framework for action: A four pillar approach to drug problems in Vancouver, Revised edition. *City of Vancouver: Vancouver, British Columbia.*

Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N.m Lal, S., & Fuhrer, R. (2018) Youth Mental Health Should be a Top Priority for Health Care in Canada. *Canadian journal of psychiatry, 63(4), 216-222*

Mahmoud, K. F., Finnell, D., Savage, C. L., Puskar, K. R., & Mitchell, A. M. (2017). A Concept Analysis of Substance Misuse to Inform Contemporary Terminology. Archives of psychiatric nursing, 31(6), 532–540. https://doi.org/10.1016/j.apnu.2017.06.004

Malla, A., Shah, J., Iyer, S., Boksa, P., Joober, R., Andersson, N., ... & Fuhrer, R. (2018). Youth mental health should be a top priority for health care in Canada. *The Canadian Journal of Psychiatry*, *63*(4), 216-222.

Marmot, M. (1993). Epidemiological approach to the explanation of social differentiation in mortality: The Whitehall studies. *38*(5), 271-279.

Marshall, B., & Spencer, J. (Eds.). (2019). Fast Facts about Substance Use Disorders What Every Nurse, APRN, and PA Needs to Know (pp. 3-18). Springer Publishing Company. doi: 10.1891/9780826161239.0001

Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *The Lancet*, *391*(10131), 1718-1735.

Mason, MJ., Keyser-Marcus, L., Snipes, D., Benotsch, E., Sood, B. (2013). Perceived mental health treatment need and substance use correlates among young adults. *Psychiatric Services, 64*(9), 871-7.

McLaughlin, A., Campbell, A., McColgan, M. (2016). Adolescent Substance Use in the Context of the Family: A Qualitative Study of Young People's Views on Parent-Child Attachments, Parenting Style and Parental Substance Use. *Substance use & misuse, 51* (14), 1846-1855

McLellan, A. T. (2017). Substance misuse and substance use disorders: why do they matter in healthcare? *Transactions of the American Clinical and Climatological Association*, *128*, 112.

Measelle, J. R., Stice, E., & Springer, D. W. (2006). A prospective test of the negative affect model of substance abuse: Moderating effects of social support. *Psychology of Addictive Behaviors*, *20*(3), 225.

Mental Health and Addictions Leadership Advisory Council. (2016). Moving Forward Better Mental Health Means Better Health: Annual report of Ontario's Mental Health and Addictions Leadership Advisory Council. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2016/moving_forward_2016.pdf

Ministry of Health and Long-Term Care. (2019). Connected care update. Ministry of Ontario. Retrieved from: http://www.health.gov.on.ca/en/news/connectedcare/2019/CC_20191113.aspx

Ministry of Health and Long-Term Care. (2018) *Substance Use Prevention and Harm Reduction Guideline, 2018.* Population and Public Health Division, Ministry of Health and Long-Term Care. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols

_guidelines/Substance_Use_Prevention_and_Harm_Reduction_Guideline_2018_en.pdf

Ministry of Ontario. (2014). *Ontario's Local Health Integration Networks. Central West LHIN*. Retrieved from: http://www.centralwestlhin.on.ca/About%20Us/Frequently%20Asked%20Questions/About%20Ontario%20LHINs.aspx

Mohajer, N., & Earnest, J. (2010). Widening the aim of health promotion to include the most disadvantaged: vulnerable adolescents and the social determinants of health. *Health education research*, *25*(3), 387-394.

National Alliance of Advocates for Buprenorphine Treatment. (2004). *Substance Use Disorders: A Guide to the use of Language.* Rockville, Maryland: Treatment Alternatives for Safe Communities (TASC), Centre for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA). Retrieved from: https://www.naabt.org/documents/Languageofaddictionmedicine.pdf

Neblett Jr, E. W., Terzian, M., & Harriott, V. (2010). From racial discrimination to substance use: The buffering effects of racial socialization. *Child development perspectives*, *4*(2), 131-137.

National Institute on Drug Abuse. (2020a), Part 1: The Connection Between Substance Use Disorders and Mental Illness. Retrieved from https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/part-1-connection-between-substance-use-disorders-mental-illness on 2020, December 4

National Institute on Drug Abuse. (2020b). Sex and Gender Differences in Substance Use. Retrieved from https://www.drugabuse.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use on 2020

National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2019). *Monitoring the Future 2019 Survey Results: Overall Findings.* Retrieved from: https://www.drugabuse.gov/sites/default/files/nida_mtfinfographic2019_fullgraphic.pdf

Nichter, M., Quintero, G., Nichter, M., Mock, J., & Shakib, S. (2004). Qualitative research: contributions to the study of drug use, drug abuse, and drug use (r)-related interventions. *Substance use & misuse*, *39*(10-12), 1907-1969.

O'Dowd, A. (2018). Avoid stigmatising language for people who use drugs, global commission urges. *BMJ: British Medical Journal (Online)*, *360*.

Olivier, A. (2020, Sept). *Treatment of dying Indigenous woman in Quebec hospital sparks outrage*. Global News. Retrieved from: https://globalnews.ca/news/7366576/racism-indigenous-woman-quebec-hospital/

Ontario Drug Policy Research Network; Office of the Chief Coroner for Ontario/Ontario Forensic Pathology Service; Ontario Agency for Health Protection and Promotion (Public Health Ontario); Centre on Drug Policy Evaluation. Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic. Toronto, ON: Ontario Drug Policy Research Network; 2020. Retrieved from: https://www.publichealthontario.ca/-/media/documents/o/2020/opioid-mortality-covid-surveillance-report.pdf?la=en

Ontario Health. 2020. *Mental Health and Addictions Centre of Excellence.* Ontario Health. Retrieved from: https://www.ontariohealth.ca/mental-health-and-addictions-centre-excellence

Ostlin, P., Braveman, P., Dachs, N., Team, W. E., & WHO Task Force on Research Priorities for Equity in Health. (2005). Priorities for research to take forward the health equity policy agenda. *Bulletin of the World Health Organization*, *83*(12), 948.

Östlund, U., Kidd, L., Wengström, Y., & Rowa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed method research designs: a methodological review. *International journal of nursing studies*, *48*(3), 369-383.

Otiniano Verissimo, A. D., Gee, G. C., Ford, C. L., & Iguchi, M. Y. (2014). Racial discrimination, gender discrimination, and substance abuse among Latina/os nationwide. *Cultural Diversity and Ethnic Minority Psychology*, *20*(1), 43.

Packer, J. (2004). A moral analysis of Canadian Drug policy. *Perspective on Canadian Drug Policy*, *2*, 9-24.

Patrick, M. E., Wightman, P., Schoeni, R. F., & Schulenberg, J. E. (2012). Socioeconomic status and substance use among young adults: a comparison across constructs and drugs. *Journal of studies on alcohol and drugs*, *73*(5), 772-782.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health services research*, *34*(5 Pt 2), 1189.

Pearson, Caryn, Teresa Janz and Jennifer Ali. 2013. "Mental and substance use disorders in Canada" *Health at a Glance.* September. Statistics Canada Catalogue no. 82-624-X. Retrieved from: https://www150.statcan.gc.ca/n1/pub/82-624-x/2013001/article/11855-eng.htm

Pedersen, ER; Tucker, JS; Klein, DJ; Parast, L. (2018). Perceived Need and Receipt of Behavioral Health Services at Drop-In Centers among Homeless Youth. *Health Services Research, 53*(6), 4609-4628.

PHS Community Services Society v. Attorney General of Canada, 2008 BCSC 661

Pope, C., Ziebland, S., & Mays, N. (2000). Qualitative research in health care: analysing

qualitative data. *BMJ: British Medical Journal*, *320*(7227), 114.

Public Health Agency of Canada (PHAC). 2020. *A primer to reduce substance use stigma in the Canadian Health System.* Retrieved from: https://www.canada.ca/en/public-health/services/publications/healthy-living/primer-reduce-substance-use-stigma-health-system.html

Public Health Agency of Canada. (2019b). Statement from the Co-Chairs of the Special Advisory Committee on the Epidemic of Opioid Overdoses on Updated Data Related to the Opioid Crisis. Retrieved from: http://publications.gc.ca/collections/collection_2020/aspc-phac/HP33-5-2019-eng.pdf

Ramirez, R., Hinman, A., Sterling, S., Weisner, C., & Campbell, C. (2012). Peer influences on adolescent alcohol and other drug use outcomes. *Journal of Nursing Scholarship*, *44*(1), 36-44.

Raphael, D. (2008). Getting serious about the social determinants of health: new directions for public health workers. *Promotion & education*, *15*(3), 15-20.

Raphael, D. (2009). Social Determinants of Health: Canadian Perspectives, 2nd edition. Toronto: Canadian Scholars' Press.

Raphael, D. (2011). A discourse analysis of the social determinants of health. *Critical Public Health*, *21*(2), 221-236.

Representative for Children and Youth. (2016). A review of youth substance use services in B.C. Retrieved from: https://rcybc.ca/wp-content/uploads/2019/04/rcy_reviewyouthsubstance-final.pdf

Rhodes, T., & Coomber, R. (2010). Qualitative methods and theory in addictions research. *Addiction research methods*, *5978*.

Riley, D. M., & Nolin, P. C. (1998). *Drugs and drug policy in Canada: A brief review and commentary*. Senate of Canada.

Robards, F., Kang, M., Usherwood, T., Sanci, L. (2018). How Marginalized Young People Access, Engage With, and Navigate Health-Care Systems in the Digital Age: Systematic Review. *Journal of Adolescent Health, 62* (4), 365-381.

Roberts, G., McCall, D., Stevens-Lavigne, A., Anderson, J., Paglia, A., & Bollenbach, S. (2008). Best pracfices for prevenfing substance use problems in Nova Scofia. *Nova Scotia Health Promotion and Protection, Addiction Services. Halifax: Nova Scotia Health Promotion and Protection*.

Robertson, E. B., David, S. L., & Rao, S. A. (2003). *Preventing drug use among children and*

adolescents: A research-based guide for parents, educators, and community leaders. Diane Publishing.

Robinson, S. M., & Adinoff, B. (2016). The classification of substance use disorders: Historical, contextual, and conceptual considerations. *Behavioral Sciences*, *6*(3), 18.

Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., ... & Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. *Substance abuse treatment, prevention, and policy*, *9*(1), 34.

Rusby, J. C., Light, J. M., Crowley, R., & Westling, E. (2018). Influence of parent–youth relationship, parental monitoring, and parent substance use on adolescent substance use onset. *Journal of family psychology*, *32*(3), 310.

Rush et al. (2008). Prevalence of co-occurring substance use and other mental disorders in the Canadian Population. *Canadian Journal of Psychiatry*, 53: 800-9.

Russell, C., Imtiaz, S., Ali, F., Elton-Marshall, T., & Rehm, J. (2020). 'Small communities, large oversight': the impact of recent legislative changes concerning supervised consumption services on small communities in Ontario, Canada. *International Journal of Drug Policy*, *82*, 102822.

Schulte, M. T., & Hser, Y. I. (2013). Substance use and associated health conditions throughout the lifespan. *Public health reviews*, *35*(2), 3.

Schreier, H., & Chen, E. (2013). Socioeconomic status and the health of youth: a multilevel, multidomain approach to conceptualizing pathways. *Psychological bulletin*, *139*(3), 606.

Sevelius, J. M., Gutierrez-Mock, L., Zamudio-Haas, S., McCree, B., Ngo, A., Jackson, A., Clynes, C., Venegas, L., Salinas, A., Herrera, C., Stein, E., Operario, D., & Gamarel, K. (2020). Research with Marginalized Communities: Challenges to Continuity During the COVID-19 Pandemic. *AIDS and behavior*, *24*(7), 2009–2012. https://doi.org/10.1007/s10461-020-02920-3

Shostak, S., Conrad, P., & Horwitz, A. V. (2008). Sequencing and its consequences: path dependence and the relationships between genetics and medicalization. *American Journal of Sociology*, *114*(S1), S287-S316.

Settipani, C. A., Hawke, L. D., Virdo, G., Yorke, E., Mehra, K., & Henderson, J. (2018). Social determinants of health among youth seeking substance use and mental health treatment. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *27*(4), 213.

Shakya, H. B., Christakis, N. A., & Fowler, J. H. (2012). Parental influence on substance use in adolescent social networks. *Archives of pediatrics & adolescent medicine*, *166*(12), 1132-1139.

Sikorski, C., Leatherdale, S., & Cooke, M. (2019). Tobacco, alcohol and marijuana use among Indigenous youth attending off-reserve schools in Canada: cross-sectional results from the Canadian Student Tobacco, Alcohol and Drugs Survey. *Health Promotion & Chronic Disease Prevention in Canada: Research, Policy & Practice*, *39*.

Sinha, R. (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of the New York Academy of Sciences*, *1141*, 105.

Sinha, J. (2001). *The history and development of the leading international drug control conventions*. Library of Parliament, Canada.

Skinner, W. W., O'Grady, C., Bartha, C., & Parker, C. (2004). Concurrent substance use and mental health disorders. *Toronto, Centre for Addiction and Mental Health*

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (2002). *Unequal treatment: confronting racial and ethnic disparities in health care: summary*. National Academy Press.

Snyder, J., Cheff, R., & Roche, B. (2016). Perceptions of the Social Determinants of Health Across Canada.

Snyder, S.M., Smith, R.E. (2015). Do physical abuse, depression, and parental substance use influence patterns of substance use among child welfare involved youth? Substance use misuse. *Substance use & misuse, 50* (2), 226-235.

Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health*. WHO Document Production Services.

Solomon, R. and M Green (1988). "The First Century: The History of Non-Medical Opiate Use and Control Policies in Canada, 1870-1970," in J. Blackwell and P. Erickson Illicit Drugs in Canada: A Risky Business, Scarbourough: Nelson Canada, pp. 88-104.

Special Advisory Committee on the Epidemic of Opioid Overdoses. Opioid-related Harms in Canada. Ottawa: Public Health Agency of Canada; September 2020. https://health-infobase.canada.ca/substance-related-harms/opioids

Spooner, C., & Hetherington, K. (2005). *Social determinants of drug use*. Sydney, Australia: National Drug and Alcohol Research Centre, University of New South Wales.

Statistics Canada. (2020). Population estimates on July 1st, by age and sex. Retrieved from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000501

Strader T.N., Kokoski C., Collins D., Shamblen S., McKiernan P. (2018) Creating Lasting Family Connections Program. In: Lebow J., Chambers A., Breunlin D. (eds) Encyclopedia of Couple and Family Therapy. Springer, Cham. https://doi.org/10.1007/978-3-319-15877-8_365-1

Strike, C., Hopkins, S., & Watson, T. M. (2013). *Best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms*. Working Group on Best Practice for Harm Reduction Programs in Canada.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2019). Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health. Retrieved from: https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014) *The TEDS Report: Age of Substance Use Initiation among Treatment Admissions Aged 18 to 30*. Retrieved from: https://www.samhsa.gov/data/sites/default/files/WebFiles_TEDS_SR142_AgeatInit_07-10-14/TEDS-SR142-AgeatInit-2014.pdf

Tariq, S., & Woodman, J. (2013). Using mixed methods in health research. JRSM short reports, 4(6), 2042533313479197.

Teddlie, C., & Tashakkori, A. (2011). Mixed methods research. *The Sage handbook of qualitative research*, *4*, 285-300.

The John Howard Society of Canada. (2003). *Perspectives on Canadian Drug Policy.* The John Howard Society of Canada. Kingston, Ontario. Volume 1. Retrieved from: https://johnhoward.ca/wp-content/uploads/2016/12/Perspective-on-Canadian-Drug-Policy-Volume-1.pdf

Tooley, J. (1999). "Demon Drugs and Holy Wars: Canadian Drug Policy as Symbolic Action." Unpublished thesis submission, University of New Brunswick.

Toronto Drug Strategy Advisory Committee. (2005). The Toronto drug strategy: A comprehensive approach to alcohol and other drugs. Retrieved from: https://www.toronto.ca/wp-content/uploads/2017/11/9767-torontodrugstrategy-rep-appendix-a-d-2005-aoda.pdf

Toronto Public Health (TPH). (2020). *Toronto Overdose Action Plan: Status Report 2020.* Retrieved June, 1, 2020, from: https://www.toronto.ca/legdocs/mmis/2020/hl/bgrd/backgroundfile-147549.pdf

Torsney, P. (2002). *Policy for the New Millennium: Working Together to Redefine Canada's Drug Strategy: Report of the Special Committee on Non-Medical Use of Drugs*. Special Committee on Non-Medical Use of Drugs. Retrieved from: https://www.ourcommons.ca/Content/Committee/372/SNUD/Reports/RP1032296/snudrp01/snudrp01-e.pdf

Truth and Reconciliation Commission of Canada. (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Truth and Reconciliation Commission of Canada.

US Department of Health and Human Services. (2016). Results from the 2016 National Survey on Drug Use and Health: Detailed Tables.

Veach, L. J., & Moro, R. R. (2017). *The Spectrum of Addiction: Evidence-based Assessment, Prevention, and Treatment Across the Lifespan*. SAGE Publications.

Virdo, G. (2012). Harm Reduction Policy, Political Economy, and Insite. *Healthy Dialogue*, *1*(1).

Waddell, C., Shepherd, C., Schwartz, C., & Barican, J. (2014). Child and youth mental disorders: prevalence and evidence-based interventions. *Vancouver, BC: Children's Health Policy Centre, Faculty of Health Sciences, Simon Fraser University*.

Wilkins, R., Adams, O., & Brancker, A. (1989). Changes in mortality by income in urban Canada from 1971 to 1986. Health Reports, 1 (2), 137-174.

Wilkinson, R. G. (2005). *The impact of inequality: How to make sick societies healthier.* New York, NY: The New Press.

Wilson, John. (1983) *Social Theor*y

World Drug Report 2018 (United Nations publication, Sale No. E.18.XI.9). Retrieved from: https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_4_YOUTH.pdf

World Health Organization. (1986). Young people's health: a challenge for society. *World Health Organization Technical Report Series*, *731*.

Wright, D. A., & Pemberton, M. (2004). *Risk and protective factors for adolescent drug use: Findings from the 1999 National Household Survey on Drug Abuse*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

Youth Wellness Hubs Ontario (2020). Retrieved from: https://youthhubs.ca/en/

Appendix A: Ontario Youth Treatment Areas

1. Addictions Treatment: This service area includes initial and ongoing assessment and treatment planning, case management activities, brief intervention, lifestyle and personal counseling to assist individuals in developing skills to manage substance use problems and/or maintain or enhance their treatment goals. Sessions could be individual, family or in group formats, with the frequency and length of sessions depending on individual need and program format. Within this service area, the individual continues to reside in the community. Other services could include relapse prevention, family intervention, follow-up and aftercare. Services may be offered in a variety of settings including home, school, agency or another service setting. Early intervention services would also be included in this area.

2. Addictions Withdrawal Management: This service area works with individuals whom are voluntarily withdrawing from alcohol and/or other substances. Clients whom access these services may also be accessing residential support services, or they may still be living at home, living with a significant other, or residing in the community- supervised or unsupervised. Care can be provided with or without the support of other treatment options or clinical interventions. Within this service realm, support with discharge and early recovery education is also provided.

3. Case Management: This service area is responsible for ongoing assessment of clients and the issues they face, ongoing adjustment of treatment plans as the situation evolves, coordination of services for clients, monitoring and support of individuals, developing and implementing discharge plans, and overall, advocating for the best interest of the client.

4. Case Management/Supportive Counselling and Services- Addictions Supportive Housing: This service area refers to the services provided by case managers and counsellors to individuals who have already been accepted into Addictions Supportive Housing (ASH) programs. ASH workers provide a variety of services, including case management services, which include housing, case coordination, community linkage, advocacy, safety planning, life skills training, financial management, relapse prevention and counselling.

5. Centralized/Coordination Access: This area acts as a centralized function within specific geographical areas for clients to access services, based on their individualized needs- essentially a hub for service coordination. This service is only used when there are dedicated staff available to provide coordination and referral services within that area. The staff at this service collect information from clients to determine which services would be most applicable and appropriate. They may also manage waitlists for agencies that are part of referral services.

6. Community Development: This service pertains to the delivery of guidance and support to a community in identifying substance use issues and developing the capacity to appropriately respond as a community.

7. Consumption and Treatment Services: These services are part of a long-term, comprehensive approach to addressing the harms associated with problematic substance use. Consumption and treatment services provide a clean and safe environment for individuals to use substances, access sterile equipment, to dispose equipment and to access safer drug use education (such as supervised consumption sites). These sites monitor individuals for signs of overdose and provide

emergency overdose prevention. The goals of these services are to reduce the number of overdoses, connect people who use drugs with appropriate services and programs, and work to reducing public safety concerns.

8. Day/Evening Care: These services provide a structured, scheduled program of treatment services and activities, typically provided approximately 5 times a week for 3-4 hours a day, whereby the client resides at home or in another setting, such as residential treatment. The goal is to support individuals in developing skills to manage their substance use issues.

9. Drug Awareness: This area relates to promoting health and education within the community, including the public, professionals and other sectors who work with in the area of impacting the health of individuals and communities, and work towards improving health statistics related to drug awareness and education. This area also works towards reducing the stigma around substance use.

10. Information and Referral-General: This formal centre is used to record the expenses and activities of information and referral services that take place over the phone, or when individuals inquire about specific programs in person, and no personal information is documented. This does not include referrals.

11. Information and Referral-Provincial: This relates to the activity of provincial information and referral services for substance use services, which take place over the phone or in-person and some demographic information is recorded. This again, does not include referral programs.

12. Residential Withdrawal Management: This service includes the assistance and support with voluntary withdrawal from alcohol and/or other substances to individuals who are under the influence of substances and/or withdrawal. Services may be provided in conjunction with drug therapy or other medical interventions. Additional support such as discharge planning and early recovery education is also provided. Services are provided by staff whom can safely monitor symptoms.

13. Residential Medical Withdrawal Management Inpatient Short term: This service area provides assistance with those that are voluntarily withdrawing from alcohol and/or other substances to individuals who are under the influence of substances or in withdrawal. Services require medically trained staff.

14. Residential Support Treatment: Supportive residential services provide safe, substance-free accommodations with low to moderate intensity of services and a level of support appropriate for longer-term treatment. This program is most suitable for those that do not require intensive residential treatment, but who do need a safe and supportive environment away from their usual living arrangements, to improve their substance use patterns. Support is often provided through a combination of peer mentoring, education, group work, life-skills training and may also include individual counselling that will help the individual positively integrate into the community when ready.

15. Residential Treatment: This service provides intensive treatment in a structured, substance-free, in-house environment, within a specific timeframe. Individuals whom are accessing these services are typically those with more complex or chronic substance use. Residential treatment programs provide daily programming that supports individuals to work on issues related to their substance use. Treatment activities could include counselling, as well as psycho-social education and life-skills training. Individuals also have access to 24/7 on-site support.

Appendix B: Survey Data set from ConnexOntario

Program Name	Service Offered By	Location
Days Ahead - Youth Substance Abuse Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Acton	Acton
Youth Family Member Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Acton	Acton
Know the D.E.A.L.	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Acton	Acton
Assessment Youth	Pinewood Centre - Ajax	Ajax
Community Treatment - Therapy and Referral Program	Windsor Essex Community Health Centre - Amherstburg	Amherstburg
Community Treatment - Continuing Care Therapy and Referral Program	Windsor Essex Community Health Centre - Amherstburg	Amherstburg
Youth and Family Program	Addiction Services for York Region (ASYR) - Aurora	Aurora
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - Aylmer	Aylmer
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Simcoe County Branch - Barrie	Barrie
Youth Community Treatment Program	Counselling Centre of East Algoma - Blind River	Blind River
Assessment Youth	Pinewood Centre - Bowmanville	Bowmanville
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Muskoka-Parry Sound Branch - Bracebridge	Bracebridge

Substance Use Community Treatment Program	YMCA of Greater Toronto - Brampton	Brampton
Impact	Canadian Mental Health Association (CMHA) Peel Dufferin Branch - Brampton	Brampton
Youth Family Member Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Burlington	Burlington
Know the D.E.A.L.	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Burlington	Burlington
Days Ahead - Youth Substance Abuse Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Burlington	Burlington
Youth Program	Four Counties Addiction Services Team (FourCAST) - Campbellford	Campbellford
Residential Program - Male (13-17)	Dave Smith Youth Treatment Centre - Carleton Place Campus	Carleton Place
Residential Program - Male (18-21)	Dave Smith Youth Treatment Centre - Carleton Place Campus	Carleton Place
Residential Program - Female (18-21)	Dave Smith Youth Treatment Centre - Carp Campus	Carp
Residential Program - Female (13-17)	Dave Smith Youth Treatment Centre - Carp Campus	Carp
Substance Abuse Community Treatment Youth	Chatham-Kent Health Alliance - Chatham	Chatham
Youth Program	Four Counties Addiction Services Team (FourCAST) - Cobourg	Cobourg
Youth Treatment Program	North Cochrane Addiction Services (NCAS) - Cochrane	Cochrane

Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Simcoe County Branch - Collingwood	Collingwood
Youth Transition Improvement Program	Cornwall Community Hospital - Community Addiction and Mental Health Services - Cornwall	Cornwall
Young Adult Residential Treatment (17 - 24 years)	Camillus Centre	Elliot Lake
Youth Community Treatment	Counselling Centre of East Algoma - Oaks Centre	Elliot Lake
Youth Health Beds	Portage Ontario	Elora
Youth Justice Beds	Portage Ontario	Elora
Residential Licence - Fee for Service Beds	Portage Ontario	Elora
Youth Community Treatment Program	Health Sciences North/ Horizon Santé-Nord, Mental Health and Addictions Program - Espanola	Espanola
Clear Directions	George Hull Centre for Children and Families	Etobicoke
Youth Substance Assessment/Referral/Counselling	Homewood Community Addiction Services - Fergus	Fergus
Youth Family Member Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Georgetown	Georgetown
Days Ahead - Youth Substance Abuse Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Georgetown	Georgetown
Know the D.E.A.L.	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Georgetown	Georgetown
Youth and Family Program	Addiction Services for York Region (ASYR) - Keswick	Georgina

Opioid Strategy: Youth Program	Eastern Ottawa Resource Centre - Gloucester	Gloucester
Community Treatment - Substance Abuse Youth	Choices for Change: Alcohol, Drug and Gambling Counselling Centre - Goderich	Goderich
Youth Substance Assessment/Referral/Counselling	Homewood Community Addiction Services - Guelph	Guelph
Getting Ready	Alternatives for Youth (AY)	Hamilton
Youth Substance Abuse Therapy	Alternatives for Youth (AY)	Hamilton
COSAP (Children of Substance Abusing Parents)	Alternatives for Youth (AY)	Hamilton
Smoking Cessation	Alternatives for Youth (AY)	Hamilton
Street-Involved Youth	Alternatives for Youth (AY)	Hamilton
Community Treatment Program	Alternatives for Youth (AY)	Hamilton
Youth Transition Improvement Program	Hôpital Général de Hawkesbury and District General Hospital Inc. - Mental Health & Addictions Regional Centre - Hawkesbury	Hawkesbury
Youth Treatment Program	North Cochrane Addiction Services (NCAS) - Hearst	Hearst
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Simcoe County Branch - Innisfil	Innisfil
Youth Program	South Cochrane Addictions Services - Iroquois Falls	Iroquois Falls
Opioid Strategy: Youth Program	Western Ottawa Community Resource Centre	Kanata
Community Treatment Youth (Substance Abuse)	Sandy Hill Community Health Centre - Addiction and Mental Health Services - Kanata	Kanata
Youth Treatment Program	North Cochrane Addiction Services (NCAS) - Kapuskasing	Kapuskasing

Choice's	Lake of the Woods District Hospital - Mental Health and Addictions Program - St. Joseph's Health Centre	Kenora
Community Treatment Alcohol and Drug Youth Program	Lake of the Woods District Hospital - Mental Health and Addictions Program - St. Joseph's Health Centre	Kenora
Community Treatment - Outpatient Program	Youth Diversion	Kingston
Community Treatment - Family Intervention Program	Youth Diversion	Kingston
Community Treatment - Continuing Care Program	Youth Diversion	Kingston
Ray of Hope - Youth Addiction: Community Treatment	Ray of Hope Youth Addiction Services Outpatient Programs	Kitchener
Ray of Hope - Youth Addiction: Residential	Ray of Hope Youth Addiction Services Residential Treatment	Kitchener
Ray of Hope - Youth Addiction: Day Treatment	Ray of Hope Youth Addiction Services Outpatient Programs	Kitchener
Youth Program	Four Counties Addiction Services Team (FourCAST) - Lindsay	Lindsay
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - London	London
Youth Community Treatment Program	Health Sciences North/ Horizon Santé-Nord, Mental Health and Addictions Program - Manitoulin	Manitoulin
Youth and Family Program	Addiction Services for York Region (ASYR) - Vaughan	Maple
Youth Program	South Cochrane Addictions Services - Matheson	Matheson
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Simcoe County Branch - Midland	Midland

Youth Family Member Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Milton	Milton
Know the D.E.A.L.	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Milton	Milton
Days Ahead - Youth Substance Abuse Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Milton	Milton
Trauma & Addictions	Manitoulin Family Resources Incorporated	Mindemoya
Youth Program	Four Counties Addiction Services Team (FourCAST) - Minden	Minden
Substance Use Community Treatment Program	YMCA of Greater Toronto - Mississauga	Mississauga
Youth Substance Assessment/Referral/Counselling	Homewood Community Addiction Services - Mount Forest	Mount Forest
Long-Term Residential - Male	Nimkee NupiGawagan Healing Centre	Muncey
Long-Term Residential - Female	Nimkee NupiGawagan Healing Centre	Muncey
Child/Youth Community Treatment Program	Community Counselling Centre of Nipissing	North Bay
Substance Use Community Treatment Program	YMCA of Greater Toronto - North York	North York
TAY (Transitional Aged Youth)	Across Boundaries - North York	North York
Days Ahead - Youth Substance Abuse Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Oakville	Oakville
Know the D.E.A.L.	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Oakville	Oakville

Youth Family Member Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Oakville	Oakville
Transitional Aged Youth Outreach Program	Alcohol, Drug and Gambling Assessment, Prevention and Treatment Services (ADAPT) - Oakville	Oakville
Residential Treatment Program	Maison Arc-En-Ciel	Opasatika
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Simcoe County Branch - Orillia	Orillia
Opioid Strategy: Youth Program	Eastern Ottawa Resource Centre - Orleans	Orleans
Assessment Youth	Pinewood Centre - Oshawa	Oshawa
Early Intervention Program Community Treatment	Royal Ottawa Health Care Group - Ottawa	Ottawa
Substance Use and Concurrent Disorders Program/ Transitional Aged Youth Service	Royal Ottawa Health Care Group - Ottawa	Ottawa
Programme de traitement communautaire pour youth et famille	Maison Fraternité / Fraternity House - Centre de traitement mixte pour les adolescents Jeunes et leur famille	Ottawa
Pathways to Wellness	Wabano Centre for Aboriginal Health	Ottawa
Programme de jour - traitement adolescent Jeunes	Maison Fraternité / Fraternity House - Centre de traitement mixte pour les adolescents Jeunes et leur famille	Ottawa
Programme résidentiel pour adolescents jeunes (es) et leur famille	Maison Fraternité / Fraternity House - Centre de traitement mixte pour les adolescents Jeunes et leur famille	Ottawa
Community Treatment Youth (Substance Abuse)	Sandy Hill Community Health Centre - Addiction and Mental Health Services - Ottawa	Ottawa

School Based Program	Rideauwood Addiction and Family Services	Ottawa
Community Treatment Youth (Substance Abuse)	Sandy Hill Community Health Centre - Addiction and Mental Health Services - Gloucester	Ottawa
Youth Addiction Treatment Program	Rideauwood Addiction and Family Services	Ottawa
Opioid Strategy: Youth Program	Rideauwood Addiction and Family Services	Ottawa
Choices Community Treatment	Choices: Drug and Alcohol Counselling for Youth a Program of CMHA Grey Bruce Mental Health and Addiction Services - Owen Sound	Owen Sound
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Muskoka-Parry Sound Branch - Parry Sound	Parry Sound
Youth Program	Four Counties Addiction Services Team (FourCAST) - Peterborough	Peterborough
Assessment Youth	Pinewood Centre - Port Perry	Port Perry
Youth and Family Program	Addiction Services for York Region (ASYR) - Richmond Hill	Richmond Hill
Youth Counselling	Bluewater Health - Norman Street	Sarnia
Youth Assessment	Bluewater Health - Norman Street	Sarnia
Rebound Choices	Algoma Family Services	Sault Ste. Marie
Alternatives for Youth - Community Treatment Program	Algoma Family Services	Sault Ste. Marie
Genesis Day Treatment Program	Algoma Family Services	Sault Ste. Marie
Substance Use Community Treatment Program	YMCA of Greater Toronto - Scarborough	Scarborough
Community Counselling	East Metro Youth Services	Scarborough
Day Treatment	East Metro Youth Services	Scarborough

Mental Health T.O.	East Metro Youth Services	Scarborough
Residence - Fee for Service	Pine River Institute	Shelburne
Shelburne Campus Program	Pine River Institute	Shelburne
Youth Treatment Program	North Cochrane Addiction Services (NCAS) - Smooth Rock Falls	Smooth Rock Falls
Aboriginal Youth Program	Oneida Human Services	Southwold
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - St. Thomas	St. Thomas
Community Treatment - Substance Abuse Youth	Choices for Change: Alcohol, Drug and Gambling Counselling Centre - Stratford	Stratford
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - Strathroy	Strathroy
Youth Community Treatment Program	Health Sciences North/ Horizon Santé-Nord, Sudbury Mental Health and Addictions Centre - Sudbury	Sudbury
Youth Outpatient Counselling	Canadian Mental Health Association (CMHA) Muskoka-Parry Sound Branch - Sundridge	Sundridge
Youth Mental Health & Addiction Service - Treatment Stream	Niagara Region Mental Health	Thorold
Youth Mental Health & Addiction Service - Transition Support	Niagara Region Mental Health	Thorold
Youth Substance Abuse Community Treatment	St. Joseph's Care Group - Sister Margaret Smith Centre	Thunder Bay
Long-Term Residential Treatment Program	Ka-Na-Chi-Hih Specialized Solvent Abuse Treatment Centre	Thunder Bay
Indigenous Youth Program	Children's Centre Thunder Bay	Thunder Bay
Case Management - TAY Outreach	St. Joseph's Care Group - Sister Margaret Smith Centre	Thunder Bay

Youth Residential	St. Joseph's Care Group - Sister Margaret Smith Centre	Thunder Bay
Youth and Family Community Treatment Program	Children's Centre Thunder Bay - Thunder Bay	Thunder Bay
Child and Youth Mental Health and Addictions Program	Misiway Milopemahtesewin Community Health Centre	Timmins
Youth Program	South Cochrane Addictions Services - Timmins	Timmins
Residential Support Treatment	LOFT Community Services - Ingles	Toronto
Children's Program (FFS)	The Wright Centre	Toronto
Substance Abuse Day Treatment Program	Hospital for Sick Children	Toronto
Pieces to Pathways	Breakaway Addiction Services - Toronto	Toronto
Transitional Age Youth Community Evening Treatment	LOFT Community Services - Toronto	Toronto
Adolescent Substance Abuse Program	Hospital for Sick Children	Toronto
Transitional Aged Youth Addiction Program	Branson Ambulatory Care Centre	Toronto
Young Carers Program	Hospice Toronto	Toronto
Family & Youth Initiatives Treatment Program	Breakaway Addiction Services - Toronto	Toronto
Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY)	Centre for Addiction and Mental Health (CAMH) - Toronto	Toronto
Substance Use Community Treatment Program	YMCA of Greater Toronto - Toronto	Toronto
Toronto Opiate Support Team	Breakaway Addiction Services - Toronto	Toronto
TAY (Transitional Aged Youth)	Across Boundaries - Toronto	Toronto
Youth and Family Program	Addiction Services for York Region (ASYR) - Markham	Unionville
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - West Lorne	West Lorne
Community Treatment - Continuing Care Therapy and Referral Program	Windsor Essex Community Health Centre - Teen Health - Main Office	Windsor

Community Treatment - Therapy and Referral Program	Windsor Essex Community Health Centre - Teen Health - Main Office	Windsor
Children's Support	Vitanova Foundation	Woodbridge
Substance Abuse Community Treatment Youth	Addiction Services of Thames Valley (ADSTV) - Woodstock	Woodstock

Appendix C: Online Survey

1. **Organization Name: _____**

2. **Please specify the program name(s) for which you are responding on behalf of:**

3. **Role in Organization: _____**

4. **Based on the 'Local Health Integration Networks' (LHINs), which region(s) does your organization serve? (Select all that apply)**
   (Click here for a map of the LHINS)

a) Erie St. Clair
b) South West
c) Waterloo Wellington
d) Hamilton Niagara Haldimand Brant
e) Central West
f) Mississauga Halton
g) Toronto Central
h) Central
i) Central East
j) South East
k) Champlain
l) North Simcoe Muskoka
m) North East
n) North West
o) Province-wide (my organization serves youth from across Ontario)

5. **Which service(s) does your organization provide? (Select all that apply)**

a) Individual counseling
b) Family counseling
c) Group counseling
d) Detoxification/withdrawal management programs
e) In-patient/residential treatment
f) Out-patient/community treatment
g) Case management
h) Relapse prevention (CBT, healthy coping skills)
i) Recovery and/or support services (continuing care, self-help groups, peer support)
j) Shelter/temporary housing (short-term)
k) Transitional housing (medium-term)
l) Educational services (training, employment)
m) Harm reduction services (needle exchange, naloxone provision)
n) Outreach
o) Other (please specify):_____

6. **Please identify the age range for the youth-oriented substance use services that your organization provides (e.g., 12-20): _____**

7. **In a given month, approximately how many youth access your organization's service(s):**

A) Less than 50
B) 51-100
C) 101-150
D) 151-200
E) 201-250
F) 251-300
G) More than 301

8. Which of the following substances do youth who access your service(s) use the most? Please rank the top three most frequently used/reported substances with 1 being the most frequently used/reported, 2 being the second most frequently used/reported substance and 3 being the third most frequently used-reported substance.

a) Opioids
b) Alcohol
c) Tobacco
d) Cannabis
e) Methamphetamine
f) Cocaine
g) Other stimulants (Ecstasy/MDMA, Adderall, Ephedrine, amphetamines etc.)
h) Hallucinogens (LSD, Magic Mushrooms, DMT, PCP, Ketamine, etc.)
i) Other (please specify):_____

-- Skip Logic – each of the three drugs ranked will be linked to a follow-up question asking them to:

9. For the substance you identified as #1 (the most frequently used/reported), please identify which intervention(s) would be the most effective in addressing issues related to that substance.

a) Harm reduction interventions (needle exchange, naloxone provision, etc.)
b) Policy interventions (legislative/regulatory change, etc.)
c) Prevention interventions (early intervention, education, focus on high-risk groups, etc.)
d) Pharmacological interventions (opioid agonist treatment, etc.)
e) Non-pharmacological interventions (cognitive behavioural therapy, motivational interviewing, etc.)
f) System improvement (integration and availability of wrap-around services, standardized data/monitoring programs, etc.)
g) Knowledge exchange activities/products (pamphlets, infographics, webinars, conferences, etc.)
h) Other (please specify): _____

10. Please specify why the intervention(s) you selected would be effective in addressing issues related to this substance._____

11. For the substance you identified as #2 (the second most frequently used/reported), please identify which intervention(s) would be the most effective in addressing issues related to that substance.

i) Harm reduction interventions (needle exchange, naloxone provision, etc.)

j) Policy interventions (legislative/regulatory change, etc.)
k) Prevention interventions (early intervention, education, focus on high-risk groups, etc.)
l) Pharmacological interventions (opioid agonist treatment, etc.)
m) Non-pharmacological interventions (cognitive behavioural therapy, motivational interviewing, etc.)
n) System improvement (integration and availability of wrap-around services, standardized data/monitoring programs, etc.)
o) Knowledge exchange activities/products (pamphlets, infographics, webinars, conferences, etc.)
p) Other (please specify): _____

12. Please specify why the intervention(s) you selected would be effective in addressing issues related to this substance._____

13. For the substance you identified as #3 (the third most frequently used/reported), please identify which intervention(s) would be the most effective in addressing issues related to that substance.

q) Harm reduction interventions (needle exchange, naloxone provision, etc.)
r) Policy interventions (legislative/regulatory change, etc.)
s) Prevention interventions (early intervention, education, focus on high-risk groups, etc.)
t) Pharmacological interventions (opioid agonist treatment, etc.)
u) Non-pharmacological interventions (cognitive behavioural therapy, motivational interviewing, etc.)
v) System improvement (integration and availability of wrap-around services, standardized data/monitoring programs, etc.)
w) Knowledge exchange activities/products (pamphlets, infographics, webinars, conferences, etc.)
x) Other (please specify): _____

14. Please specify why the intervention(s) you selected would be effective in addressing issues related to this substance._____

15. Which of the following services does your organization currently not offer, but would be useful to offer (for youth) in the future? (Select all that apply)
a) Individual counseling
b) Family counseling
c) Group counseling
d) Detoxification/withdrawal management programs
e) In-patient/residential treatment
f) Out-patient/community treatment
g) Case management
h) Relapse prevention (CBT, healthy coping skills)
i) Recovery and/or support services (continuing care, self-help groups, peer-support)
j) Shelter/temporary housing (short-term)
k) Transitional housing (medium-term)
l) Educational services (training, employment)
m) Harm reduction services (needle exchange, naloxone provision)
n) Outreach
o) None or N/A
p) Other (please specify): _____

16. What are some of the key challenges in accessing youth-oriented substance use services in your region? (Select all that apply)
a) Geographically inaccessible

b) Lack of resources (staff, equipment)
c) Lack of programs
d) Lengthy wait times
e) Fear of stigma or discrimination
f) Restrictions on eligibility for programs/services
g) None or N/A
h) Other (please specify): _____

17. Which of the following substances do you think youth-oriented substance use research should focus on/prioritize over the next 3 to 5 years? Please rank the top three substances with 1 being the substance you feel should be most prioritized, 2 being the substance you feel should be the second most prioritized and 3 being the substance you feel should be the third most prioritized.

a) Opioids
b) Alcohol
c) Tobacco
d) Cannabis
e) Methamphetamine
f) Cocaine
g) Other stimulants (Ecstasy/MDMA, Adderall, Ephedrine, amphetamines etc.)
h) Hallucinogens (LSD, Magic Mushrooms, DMT, PCP, Ketamine, etc.)
i) Other (please specify):_____

18. Please provide any additional context, comments or feedback that you would like to share._____

19. Are you willing to participate in a key informant interview to further discuss your perspectives/recommendations on improving substance use service provision and access for youth? The information you share will remain confidential and anonymous, and you will receive compensation for your time and participation in the interview.

a) No
b) Yes

- Please provide an email address where we can contact you: _____

20. Please provide an email address where we can contact you:_____

Appendix D: Key informant Interview Guide

1. How does your organization define youth?

Probe: Cut-offs? Eligibility?

2. Generally speaking, who is seeking treatment for youth? Are youth seeking help independently or are parents/schools/pushing for services?

3. From the data collected, cannabis was reported as the most frequently used substance among youth whom access services for substance use across Ontario. In your opinion why do you think that is? Do you believe that cannabis use is a problematic substance?

   Probe: Of the youth that seek your service, are they specifically seeking support/treatment for their cannabis use?

   Probe: Have you seen an increase in service access for youth since legalization?

   Probe: Do you believe cannabis is a substance that requires services to support youth? (If yes then ask 4)

4. And what do you think are the most effective services for youth who are seeking support for their cannabis use?

5. Do you feel that you and/or your organization are well-equipped to effectively deal with problematic cannabis use among youth?

6. From the data collected, alcohol was reported as the second most frequently reported/used substance among youth whom access services across Ontario. In your opinion, why do you think that is? Do you believe that alcohol is a problematic substance?

   Probe: Of the youth that seek your service, are they specifically seeking support/treatment for their alcohol use?

7. The most commonly selected barrier for accessing services was fear of stigma. How do you feel that this effects youth and their ability to receive effective services for their substance use problems? Is there anything that can be done to reduce the stigma and/or address this concern?

8. One of the services that were selected as not offered but would be helpful, was detoxification. Can you comment on why you think this might be and/or how detoxification would be a useful service to offer in light of this finding?

   Probe: Which substances are you referring to?

9. When asked about future research priorities, cannabis, alcohol and opioids were identified as the top 3 priority substances. Taking these findings into consideration, which types of interventions (i.e. education, harm-reduction services etc.) do you feel would be most effective when working with youth?

10. That wraps up our interview, are there any other additional comments that you would like to add at this point?