EQUIPPING CHANGEMAKERS

EXPLORING NORTH ISLAND COLLEGE'S POTENTIAL TO SPUR CULTURE, COMMUNITY, AND SYSTEMS CHANGE IN RESPONSE TO THE TOXIC DRUG CRISIS

Comox Valley Report

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With Gratitude to Our Partners

And Funders

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LAND ACKNOWLEDGEMENT

We recognize and humbly acknowledge our place on the unceded traditional territory of the K'ómoks First Nation. We give respect to this land and to the K'ómoks People who have been its caretakers since time immemorial.

DEDICATION

This piece is dedicated to all who shared their stories, insights, and courage, and to those whose lives have been lost. We honour all whose names have been spoken in memory—whose stories compel us forward in pursuit of transformation. We honour you and think about you often—especially when we walk.

ETHICS STATEMENT

The research described in this work has received human research ethics approval from the Thompson Rivers University and North Island College Offices of Research Ethics.

ABSTRACT

Since labelled a provincial emergency in 2016, the toxic drug poisoning crisis in B.C. has claimed over 14,000 lives. Government, health, and community service providers alike have struggled to find solutions to the crisis, developing numerous interventions aimed to reduce deaths, harm, and stigma. Despite these efforts, toxic drug deaths have continued to climb each year. "Walk With Me – NIC" is a research and community action project, developed in the Comox Valley, B.C. as a partnership between Comox Valley Art Gallery's Walk With Me project, North Island College (NIC), Thompson Rivers University, and AVI Health & Community Services that aims to develop humanist and systems-based solutions to this crisis. The project brings people impacted by the crisis together for story and insight-sharing, and disseminates key findings outward—to policy-makers, systems leaders, and community members at-large. This publication explores North Island College's current and potential role in responding to the crisis. We aim to illuminate ways forward for community and systems transformation.

Keywords

{ toxic drug poisoning crisis, systems change, stigma reduction, policy, community action }

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LIST OF KEY TERMS

Benzodiazepines: A class of depressant drugs sometimes used for treatment of anxiety; when combined with other drugs, they can increase toxicity and propensity for fatality.

Fentanyl: A synthetic opiate, approximately 100 times more potent than morphine and 50 times more potent than heroin.

Naloxone: A medication that rapidly reverses the effects of a drug poisoning by opioids, often referred to by the brand name “Narcan.”

OAT: Opioid Agonist Therapy: treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone, fentanyl, and percocet. The therapy often involves taking Opioid agonists like methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid drugs.

OPS: Overdose Prevention Site: designated sites where drug consumption is witnessed, supporting immediate response in the event of a toxic drug poisoning.

Peer(s): In this report: people who use (or have used) substances.

Safe(r) Supply: A practice that allows prescribers to give access to maintenance doses of pharmaceutical alternatives to unregulated toxic substances within a Harm Reduction paradigm.

1 INTRODUCTION

ABOUT THIS REPORT

At the heart of this report lies the question: **How can North Island College (NIC - Comox Valley Campus) spur culture, community, and systems change in response to the Toxic Drug Poisoning Crisis?**

Since labeled a provincial public health emergency in 2016, the toxic drug poisoning crisis has taken over 13,000 lives in the province.[1(p2)] Our team set out to better understand the role North Island College (NIC) is currently playing, and might play in the future, to foster a transformative community and institutional response. Our work explores change potentials for reducing mortality and morbidity caused by this crisis and improving quality of life for people who use substances and their friends/families. This exploration occurs both on an institutional level, recognizing NIC's responsibility to its employees and students struggling with the crisis first-hand, and on a community level, recognizing NIC's role in training future leaders and in responding to community need.

We premise the report on the belief that locally driven systems and community change is possible. While numerous external forces impact the toxic drug crisis, including national and provincial drug policy, local leaders remain essential for catalyzing change. Major institutions in small cities have significant roles to play in modeling and innovating change.

In particular, education and educational institutions produce community wellness and foster community resilience in response to this crisis. Recognizing the many ways in which Canada's post-secondary landscape is shaped by histories of oppression and colonization and the work that is still needed to confront these histories and find new pathways forward, we see evidence of powerful change initiatives happening in education. We see initiatives that enact social justice and systems change beyond the institutional level. As Carolyn Shields and Andréanne Gélinas-Proulx have recently argued, educational institutions and their leaders can play invaluable roles in not only identifying but in addressing the intersectional inequities that affect students, staff, and all others that their institutions interact with.[2] Moreover, academic institutions play a role in driving advocacy and activism that affects change far beyond the campus. We believe this educational potential is true in relation to the toxic drug

crisis. Educational institutions are uniquely positioned to mobilize long-term community change. They have the power to model change internally, equip future leaders as they enter the workforce, address inequities in income and other health determinants on the local level, and foster social innovation.[2] Institutions, such as community colleges, hold tremendous power to mobilize relevant and localized change capacities and programs that are responsive to community need.

We believe in the importance of change leadership for responding to the crisis. In contrast to change management—a term that describes a change strategy based on "small scale wins"—change leadership involves "the power of vision—translating a mission from paper to daily business operations."[3] Leadership includes agitators (those calling attention to the need for change), innovators (those creating actionable solutions), and orchestrators (those who take the innovators' plans and action them across groups, organizations, sectors).[3] All three roles are essential to craft large-scale institutional, community, and systems change. We see potential for NIC to adopt these roles and become a leader in response to the toxic drug crisis.

This report, "*Equipping Changemakers*", is the culmination of a two-year research project entitled "Walk With Me – NIC," which was developed as a collaboration between the Walk With Me Team (a social action and research team hosted by the Comox Valley Art Gallery), North Island College's Faculty of Health and Human Services, AVI Health and Community Services, and Thompson Rivers University. The work has been funded by the Comox Valley Community Foundation. While the report predominantly centres conversations with student and faculty in the NIC Faculty of Health and Human Services, the issues it addresses are College wide. We see Health and Human Services as a change-agent within the College with the potential to spearhead a conversation urgently needed throughout the institution at-large.

The report includes five chapters in addition to this introduction. Our Context chapter walks readers through various contextual factors that inform the findings in this report. It includes an illustration of the gravity of the crisis and its impact in the Comox Valley. The Methods chapter reviews our research and knowledge mobilization praxis. The Findings chapter shares key insights that emerge from over 19 research sessions with NIC students, faculty, and staff. The Recommendations chapter presents a series of strategic development avenues for NIC's leadership to consider. Our Conclusion summarizes the report, the status of our project, and our recommendations for next steps. These pieces together provide a framework to spur understanding and action.

In moving through this report, we ask readers to check in with themselves as the themes and stories we present can be unsettling. The lives lost to the crisis continue to impact many. We invite readers

to self-monitor while reading and put down the report when needed. We encourage those who read to think in advance about the supports available to them—including informal supports, such as self-reflection and sharing conversation with loved ones—and formal supports, such as professional counseling. We remind North Island College students and faculty to consider reaching out to in-house NIC counseling services.

Overall, this report's aim is to generate new forms of solidarity and action in response to a devastating crisis. We look forward to continuing to walk together.

2 TOXIC DRUG POISONING CRISIS – CONTEXT

2.1 History

In April of 2016 the province's Health Officer, responding to rising numbers of toxic drug poisoning deaths within British Columbia, declared a public health emergency under the Public Health Act—a designation that continues into the present.[4] In recent years BC has consistently shown the highest per-capita rates of apparent illicit drug toxicity deaths in comparison with other provinces.[5] Between 2016 and 2023, over 14,000 people died in BC as a result of the toxic drug poisoning crisis,[1(p2)] and deaths for this period were substantially higher than unnatural deaths from other common causes, including suicide, motor vehicle incident, and homicide.[6(p4)] Over the course of the COVID-19 pandemic (2020–2022), the number of deaths in BC resulting from toxic drug poisoning (6,352) was substantially higher than the number of deaths resulting from COVID-19 (4,806).[1(p2),7']

The move to label the toxic drug poisoning crisis a provincial emergency was a first in BC and Canada, and it triggered a multi-faceted intervention that aimed to save lives and reduce harm for people who use drugs. Elements of this intervention have included: public education, targeted information campaigns, connection with People With Lived and Living Experience, increased access to treatment for Substance Use Disorder, distribution of naloxone to reverse drug poisonings, legislative changes, increased toxicological testing of drugs, expansion of harm reduction services (for example, establishing drug poisoning prevention services and expanding supervised consumption sites), establishing the Ministry of Mental Health and Addictions, and more. In 2019, the province claimed that such interventions had "averted 60 per cent of all possible drug poisoning deaths since the declaration of the public health emergency," and indeed that same year the province's illicit drug toxicity death number dropped significantly for the first time since 2012.[1(p2),4(p3)] The 2019 death toll in B.C. showed a 37% reduction in comparison to the previous year—with total illicit toxicity deaths falling to 988 (2019) from 1,561 (2018).[1(p2)]

Yet despite these significant reductions in deaths, the onslaught of the COVID-19 pandemic appeared to counteract this reversal, with deaths nearly doubling in 2020 over 2019 and failing to decrease substantially since.[1(p2)] Numerous

authorities, including BC's chief coroner Lisa Lapointe and the Public Health Agency of Canada, identify the pandemic as having significantly exacerbated this provincial and national crisis.[8,9]

2.2 Impact

Our knowledge of this ongoing crisis is informed by data collected by the Province of British Columbia, Vancouver Island Health Authority, First Nations Health Authority, BC Coroners Service, BC Centre for Disease Control, and other health, government, and community service agencies. In what follows, we review key statistics that have emerged since the crisis was labeled a provincial emergency, placing emphasis on the most recent numbers.

2.2.1 Who is Most Impacted by this Crisis?

Knowing who the crisis impacts most helps to shape public policy, systems change strategies, and community action.

- **The crisis disproportionately impacts middle-aged men.** In 2022, 70% of those dying of drug poisoning in BC were between ages 30 and 59. Males accounted for 78% of deaths. Similar figures are reported for 2016 – 2021.[1(pp3-4),10–12]
- **The crisis disproportionately impacts Indigenous People.** 16% of drug poisoning deaths in BC in 2022 were First Nations people. This number was less than 10% in 2019. Both numbers are significant as First Nations represent 3.3% of the province's population.[13(p3),14]
- **Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in drug poisoning statistics.** While the crisis at-large in B.C. disproportionately affects men, 40.5% of toxic drug poisoning events among First Nations affected women, compared to 23.1% of women among other residents in B.C.[13(pp4-5)]
- **The crisis disproportionately impacts people who are unemployed as well as people in the trades and transportation industries.** A study of 872 drug poisoning deaths in BC from 2016 & 2017 shows that most people who experienced toxic events were unemployed (66%). Of those employed, 55% were employed in the trades and transport industry.[15(p5)]
- **The crisis disproportionately impacts people who are grappling with pain and mental health issues.** The same study shows 79% of drug poisoning death victims had contact with health services in the year preceding death (690/872). Over half (56%) had contact for pain-related issues (389/690). More than half of the cohort (455/872) (52%) were reported to have had a clinical diagnosis or anecdotal evidence of a mental health disorder.[15(p5)]

- **Most drug poisoning victims live in private residences.** The above-mentioned study from 2016 & 2017 shows 72% of drug poisoning victims as having lived (and experienced poisoning events) in private residences, 13% as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.[15(p5)]
- **Most drug poisoning victims are not married.** 65% percent of those who had experienced drug toxicity in the study had never been married.[15(p5)]
- **Most drug poisoning victims use drugs alone, rather than with other people.** The majority of those who experienced a fatal drug poisoning event (69%) had used their drugs alone.[15(p5)]
- **Fatal drug poisoning events increase during income assistance payment week.** A BC Coroners Service Report analyzing data in 2021 and 2022 shows the daily average of drug poisoning deaths in the province as having risen from 5.7 to 8.7 in the four days following income assistance payment day (Wed – Sun).[6]

Though limited, these statistics help inform a demographic profile for victims of toxic drug poisoning. From them we understand that this crisis most severely impacts middle-aged men and Indigenous peoples, especially Indigenous women. We also see the crisis' inordinate impact on those with pain management and mental health issues. We observe an inverse correlation between toxic drug poisoning rates and income and recognize a higher rate of drug poisoning amongst those who access income assistance and are unemployed.

These statistics do not adequately portray the full picture. We know that people from all walks of life are impacted by this crisis—including people from high- and middle-income backgrounds, women, people in a wide range of professions including doctors, police officers, etc. Readers should be aware that these statistics only tell part of the story.

2.2.2 Where is this Crisis Unfolding?

An understanding of where this crisis is unfolding helps inform knowledge of its "on the ground" impacts. While many see the toxic drug poisoning crisis as predominantly confined to large urban areas due to its high visibility in these centres, this is not actually the case. Opioid use and drug poisoning rates in rural areas and small cities and towns are growing, and in some cases far surpass rates in large urban centres. For example, per capita, BC's highest rates of fatal drug poisonings in 2022 were found in the Northern Health Authority.[1(p5)]

According to a national study by Canadian Institute for Health Information with data from 2017, "opioid poisoning hospitalization rates in smaller communities were more than double those in Canada's largest cities."[16] Another report, produced as part of the BC Rural and Indigenous Overdose

Action Exchange shows that between 2016 and 2019, small and mid-sized BC communities "made up between 23-27% of all paramedic attended drug poisoning events."[17(p8)] And a recent study by BC Emergency Health Services shows that although urban centres in BC witnessed the deadliest effects of the crisis in 2020, rural and remote areas also witnessed significant spikes in drug poisoning calls to 911. Some of the highest increases in drug poisoning calls were found on the BC coast and in small cities on Vancouver Island.[18,19] These statistics challenge the view that the crisis exists only in large urban centres.

2.2.3 How is the Toxic Drug Poisoning Crisis Unfolding in Vancouver Island Health Authority and in the North Island Service Delivery Area?

Between 2016 and August 2023, Island Health recorded 2,155 illicit toxicity deaths.[1(p5)] This figure represents the third-highest death rate recorded amongst BC's Health Authorities, following Fraser Health Authority (4,229), Vancouver Coastal Health Authority (3,731), and just ahead of Interior Health (2,151).[1(p5)]

Drilling down to the regional level to look at the number of deaths in the individual Service Delivery Areas (SDA) of Island Health for 2016 - August 2023, the majority of drug poisoning deaths have occurred in South Vancouver Island SDA (945) followed by Central Vancouver Island (858), and North Vancouver Island (352).[1(p7),20] These raw numbers suggest that large urban centres on Vancouver Island are experiencing the worst of the crisis when examining drug toxicity deaths per-capita (per 100,000 people); but when we average out drug toxicity death rates by SDA for the same period, we see the highest illicit drug toxicity death rates occurring within Central Vancouver Island (38.9), followed by North Vancouver Island (35.0), and then South Vancouver Island (29.2).[1(p7)] In this snapshot, Central Vancouver Island appears to be the SDA most affected by the crisis—with North Vancouver Island now surpassing South Vancouver Island.

This data shows that the small urban areas of Nanaimo, Duncan, Campbell River, and the Comox Valley, are significantly impacted by the crisis and are witnessing drug poisoning rates greater than the large city of Victoria and its surrounding areas. While North Vancouver Island SDA has to date escaped the worst of the toxic drug poisoning crisis, when compared to some areas of the province—as measured in both numbers and rates of illicit toxicity deaths—it has nonetheless suffered a substantial blow, and the effects appear to be getting worse.[1(p7)]

2.2.4 How is the Crisis Unfolding in the Comox Valley?

Within North Vancouver Island SDA, there is a strong concentration of drug poisonings in the Comox Valley Local Health Area (Comox Valley). Of the 352 illicit drug toxicity deaths that occurred in the North Island SDA between 2016 and August 2023, 169

occurred in the Comox Valley. In 2022 alone, 37 illicit drug toxicity deaths occurred in the Comox Valley. In terms of total number of deaths per year in the North Island SDA, the numbers have steadily increased over the 2016-August 2023 period.[1(pp7-8)] When examined in rates (in contrast with total numbers), the average rate (per 100,000 people) of fatal drug poisonings in the Comox Valley in the same time period is 29.2.[1(p7)]

It is common for people with opioid use disorder to have multiple morbidity factors, and their deaths can be classified in ways other than as "illicit drug toxicity." While these numbers help to inform our understanding, we recognize that the toxic drug poisoning crisis cannot be fully understood through numeric representation. This is a human crisis that cannot be adequately expressed or understood through statistics.

2.2.5 How is the Crisis Being Addressed by Health Systems?

The toxic drug poisoning crisis, and related housing and mental health crises, have a major impact on health care systems in B.C. and beyond. Emergency Departments in particular are hard-pressed to meet an increased flow of toxic drug-related events.[21,22] A recent report released by the Provincial (BC) government acknowledges the "critical need" to ensure "trained personnel are available in hospital emergency rooms to refer individuals to harm reduction or treatment services."[23(p9)]

The Walk With Me team has also identified the need for additional resources and training in a recent study predominantly involving front-line staff in Comox Valley, Campbell River, and Oceanside/Parksville Hospitals. The report indicates the need to reduce caseloads, bolster addictions and mental health supports in Emergency Rooms, strengthen humanizing and welcoming practices, and actively reduce stigma.[24] Clearly the crisis is changing our health care system—students entering the system should be well-prepared to meet this reality.

2.2.6 How are Colleges and Universities Addressing the Crisis?

The toxic drug crisis impacts college and university campuses throughout BC, Canada, and abroad. Recent news articles highlight the significant number of Canadian students, both domestic and international, that are adversely affected by the toxic drug poisoning crisis, even as it is difficult to pinpoint the degree of loss.[25–27] Publicly accessible information from the BC Coroners Service lacks "non stigmatizing, fulsome, accurate data" to help provide better detail.[26] Various resources encourage compassionate responses within the campus environment. These advocate for proactive and "designed" forms of intervention—from the policy-level (i.e.: the implementation of harm reduction policies), to the student services level, to the academic support level.[28] Campuses, and especially ones with overnight residences, are implementing a wide range of harm

reduction services, including (but not limited to): the provision of fentanyl test strips and drug testing equipment, response protocols for drug poisoning events, widespread Naloxone training, Peer and student-led help lines, and more.[29,30] While there is a lack of accurate data to indicate just how many students, and how much impact the toxic drug poisoning crisis is having on colleges and their students in Canada, conversations are happening, and awareness is growing.

The extent of the crisis, and the fact that it is hitting student and employee populations in unprecedented ways and at unprecedented levels, is causing a rapid-response evolution of harm reduction procedures at campuses across the country. New forms of education are needed, and nursing and medicine programs are particularly well-positioned to address the crisis head-on: to enact change from the ground-up, at the educational level, before students enter the workforce and front lines.

2.3 Key Contributing Factors

A "perfect storm" has fueled the toxic drug poisoning crisis: an increasingly toxic, novel, and unpredictable supply of unregulated drugs, over-prescription of opioid-based pain medication, increased criminalization of drugs, the COVID-19 Pandemic, and the rise, throughout Western Society and globally, in social dissonance factors such as unemployment, housing unaffordability, and income disparity. These factors, coupled with ongoing stigma, racism, and erosion of mental health supports, describe the landscape that fosters the toxic drug poisoning crisis. The following outlines the context for how this crisis has emerged and why it is flourishing.

2.3.1 Increase in Toxic Supply

The rise of fentanyl is a primary factor in driving the toxic drug poisoning crisis. Fentanyl is a synthetic opioid that is roughly 100 times more potent than morphine and 50 times more potent than heroin. It is legally used and distributed in pharmaceutical practice.[31] It is also made and distributed illegally through various supply channels. Illegal dealers order highly concentrated fentanyl online, and they receive packages from outside the country through mail or courier. Packages contain hyper-concentrated small quantities that can evade detection by the Canada Border Services Agency (CBSA) since the CBSA requires a supplier's permission to open packages weighing less than 30 grams.[32] Fentanyl traffickers range from organized crime operations to lone operators. Once the drug is in the country, it is diluted, cut with fillers (such as powdered sugar, baby powder, or antihistamines), and mixed with other drugs such as heroin, or packed into pills which are often made to look like OxyContin.[33] According to Edmonton physician Hakique Virani: "A kilogram of pure fentanyl powder costs $12,500. A kilo is enough to make 1,000,000 tablets. Each tab sells for $20 in major cities, for total proceeds of $20 million. In smaller markets, the street price is as high as $80."[33(para16)]

Toxicity in the supply of fentanyl stems from its frequent manufacture in unregulated sub-standard labs, its mixture with other toxic substances, and its high level of potency. Drug Toxicity Alerts issued by Health Authorities are now common in B.C.[34] It is often the case that a "bad batch" of fentanyl-containing drugs will move from a large urban centre outward into neighbouring small centres and beyond.[35,36] Over the past 11 years in BC, fentanyl has been detected in increasing numbers of apparent illicit drug toxicity deaths. While this rate stood at 15% in 2013, in 2022 it had increased to a staggering 86%.[1(p12)] Notably, when the US border was closed during the COVID-19 pandemic, drug supply chains were interrupted; this event resulted in an increase in drug toxicity.[37]

While more fentanyl is crossing into Canada and is linked to the rise in fatal drug poisoning events, new and even more dangerous illicit street drugs are also entering the scene including carfentanil and W18, both of which are more powerful than fentanyl and carry a high risk of initiating a toxic drug event.[38] Methamphetamine use is also on the rise in B.C.'s supply—a stimulant that is regularly cut with fentanyl and other toxic substances.[1(p11),39] At the same time, benzodiazepines (commonly prescribed to treat anxiety and depression) are also being added to fentanyl and other illicit drugs and are associated with increasing numbers of toxic drug deaths.[39]

2.3.2 Provision of Safe(r) Supply

In March 2020, BC's then-Minister of Mental Health and Addictions, Judy Darcy, announced new guidelines for prescribers aimed to support drug users with "safe supply."[40] These guidelines, which allow certain eligible populations of drug users to access prescription drugs from limited classes of health professionals, were designed in part to help stem the consequences of an increasingly toxic supply reaching the public during the pandemic.[41,42,43] The roll out of this landmark initiative is encountering various "bottlenecks," namely under-resourcing and the challenge of construction of new protocols and systems, though delays were not unexpected as "B.C. [is] the first province or territory in Canada to pursue safer supply so aggressively."[42] BC's Ministry of Mental Health and Addictions has committed publicly to creating safe supply programs across the province—but the realization is taking time.

The public is impatient to see real change and experts are challenging the government's claims of progress to date.[44] At the same time, critics of safe supply raise concern for "diversion" of drugs by drug users and claim that safe supply is making the problem worse, not better.[45] Such critiques have been soundly rebuffed by BC government officials, and there is no evidence that safe supply programs are contributing to deaths from illicit drugs.[1(p1),45]

2.3.3 Opioid Agonist Therapy (OAT)

Safe supply is in part an extension of Opioid Agonist Therapy (OAT)—a treatment strategy that has been in-place within B.C. for many years (since 1959). OAT involves prescription of opioid agonists such as methadone (Methadose) and buprenorphine (Suboxone) which are long-acting opioid drugs provided in daily doses to replace shorter-acting opioids such as heroin, oxycodone, and fentanyl.[46(p444)] OAT is often considered the first line of treatment for Opioid Use Disorder. In BC, the College of Physicians and Surgeons of British Columbia (CPSBC) oversees OAT guidelines, tracks and monitors patients and physicians, and mandates the concurrent treatment of mental health and addictions.[46(p448)]

OAT reduces opioid-related morbidity and mortality, and this is increasingly so as synthetic opioids such as fentanyl become more dominant in the illicit drug supply.[47(p1)] A recent meta-analysis demonstrated that retention in OAT is associated with two to three times lower toxic drug-related mortality in people with Opioid Use Disorder.[48(p2)] However, low quality OAT service provision prevents or slows uptake and retention.[49] We characterized temporal trends in engagement in care for opioid use disorder (OUD Improved OAT delivery (that incorporates best practice guidelines) positively impacts uptake and retention of this service.[50] Recognizing the role OAT plays in preventing drug poisonings, the province needs to continue to systemically upgrade service delivery.

OAT—and by extension safe supply—roll-out happens differently in large urban centres than in small cities and rural locales. Best practice guidelines for OAT advocate for "continuity of care" between multidisciplinary teams of Service Providers, including "physicians, nurses, substance use counselors (with specific methadone expertise), social workers, probation officers, community mental health liaison workers, etc."'[51(pp81-82)] Providing such "wrap-around" support services in small communities that face shortages of health services and professionals is far more challenging than in large urban centres.[46(p446)]

Furthermore, OAT delivery in Canada is tied to contingency management strategies that allow patients to take their doses home with them as they stabilize. "Carry privileges" are increased "based on appointment attendance and consistently negative urine screens for opioids, stimulants, and other substances".[46(p447)]

For OAT clients in rural and/or remote locations, transportation barriers disrupt regular access to OAT clinics and physicians, as well as to the wrap-around services identified above. These same challenges facing systems of OAT provision are present in the roll-out of safe supply.

2.3.4 Over-Prescription of Opioid-Based Pain Medication

Medical institutions feed opioid dependency through prescription. Canada ranks "second

only to the US in per capita consumption of prescription opioids" as a nation.[52(para1)] This is in part due to a liberal approach to the prescription of pain medication.[46(p446)]

National clinical practice guidelines published during the early days of the crisis, in 2010 (the *Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain*), offered few parameters to prescribing physicians: "Many of the recommendations were nonspecific and almost all supported the prescribing of opioids; the guideline provided few suggestions about when not to prescribe."[53(pE659),54] Between 2010 and 2014, opioid prescribing across Canada increased steadily by 24%, with 21.7 million prescriptions dispensed nationally in 2014.[46(p446)]This increase in prescription rates resulted in a "massive swell" in opioid dependency.[46(p446)]

Regulatory bodies have been working to come to terms with the damage associated with rising opioid dependency. The 2017 update to Canada's national clinical practice guidelines (*Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain)* differs from its 2010 counterpart by introducing restrictive opioid prescription guidelines, including recommendations to enter into "opioid prescription modalities slowly, with short durations of use and a maximum dose."[53,55,56(p7)] Other regulatory initiatives include reformulating long-lasting oxycodone into a "tamper-deterrent form" to address concerns related to misuse of OxyContin and developing and expanding provincial prescription monitoring programs with enhanced prescriber education.[56] The response is fragmented as key elements of health regulations and policy are not provincially and nationally harmonized.[55(p1)]

Despite this fragmentation, government initiatives to restrict opioid prescription are somewhat effective. From 2016 to 2017, the total quantity of opioids dispensed in Canada decreased by more than 10%, and the number of prescriptions for opioids fell by more than 400,000: the first decline seen since 2012.[57(p1)] However, by adding deterrents to opioid prescription practices, the measures also increased demand for toxic street supply, as regular opioid users were in many cases compelled to seek illicit supply from the street when denied pharmaceutical supply.[58]

Research reveals strong systemic factors that drive individuals towards dangerous substances. These factors include, for example, changes in illicit drug market production practices that result in increased toxicity of street supply; bottlenecks and inadequacies in government response mechanisms (OAT and safe supply) that are designed to provide pharmaceutical alternatives to illicit street supply; and a history of opioid over-prescription that, coupled with consequent efforts to restrict and regulate prescription, cultivate displaced opioid dependency and increase demand for (toxic) street supply.

2.3.5 Criminalization

Criminalization of people who use drugs—a product of attempted prohibition—compounds negative outcomes globally. Throughout history, prohibition has stimulated unregulated drug innovation and the growth of associated crime and social ills.

The *Opium Act* of 1908 was developed as part of a nation-wide attempt to control non-British immigrant populations, and today it still informs the legal framework for Canada's drug control policy, as well as alcohol, tobacco, and medicine regulations.[59,60] In 1911, the *Opium and Drug Act* added other opiates and Cocaine to an expanded list of prohibited substances, followed by cannabis in 1923.[59] Bans on alcohol and tobacco consumption were repealed by most provinces during the 1920's.

In 1969 Pierre Trudeau's government ordered an investigation into drug law reform. The resulting Commission of Inquiry into the Non-Medical Use of Drugs (also called the LeDain Commission) recommended the following in its final report to Cabinet in 1973: a repeal of the criminalization of cannabis, no increase in penalties for other drug offences, and in relation to those dependent on opioids, an emphasis on "treatment and medical management rather than criminal sanctions."[61(para3)] However, his government and those that followed into the first decade and a half of the 21st century advanced policies in direct opposition to this commission's recommendations.

The most recent and memorable government-led prohibitionist effort includes the War on Drugs. Shortly after U.S. President Ronald Reagan had popularized this call to arms and policy, in 1986 Canada's Prime Minister Brian Mulroney declared that "drug abuse has become an epidemic that undermines our economic as well as social fabric," a claim that was counter to both evidence and popular sentiment.[60(p123)] In 1987 the government announced the Action on Drug Abuse: Canada's Drug Strategy and injected $210 million into the nation's fight against drug use.[59] A substantial portion of these funds were earmarked for enforcement.[62(p2)] In 1996, the Controlled Drugs and Substances Act was passed—a significant piece of legislation that further expanded prohibition.[59] Finally, in 2007, the Harper government released the National Anti-Drug Strategy, which removed the harm reduction pillar from the nation's drug strategy and emphasized "busting drug users [rather] than helping them."[63,64] This framework of increasingly prohibitionist legislation led to a situation in which drug arrests in Canada totaled over 90,500 in 2017, over 72% of which were for drug possession.[65(p1)]

The lasting rhetoric and propaganda of the War on Drugs has exacerbated Canada's drug issues. Its punitive approach to people who use substances produced the most severe penalties in the country's criminal code "surpassed only by offences such as

assault or murder."[66(p65)] It allowed police "far broader enforcement powers in even a minor drug case than they have in a murder, arson, rape, or other serious criminal investigation."[67(p263)] Amplified penalties for drug possession and trafficking, coupled with an expansion of police enforcement powers, have contributed to the erosion of civil liberties and human rights in Canada, while criminal justice costs associated with substance use have increased—rising in 2017 to over $9 billion.[59,68,69]

Drug enforcement policy has never been applied to all citizens equally. Professor Todd Gordon traces the federal government's evolving drug laws and legislative frameworks throughout the 20th century and into the 21st as aligned with attempts to control non-British immigrant and racialized communities.[66] For Gordon, "Drug enforcement became an excuse for the police [...] to intervene in and assert their control in communities, on the streets, and in public spaces—regardless of whether those being targeted were actually violating drug laws."[66(p68)] Moreover, federal drug laws developed throughout the 20th century were "often based on moral judgments about specific groups of people and the drugs they were using (e.g. Asian immigrants who consumed Opium)" rather than on "scientific assessments of their potential for harm."[70(p2)] Various studies demonstrate that these laws are still used to enforce systemic forms of anti-Black, anti-Indigenous, and anti-immigrant racism.[71–73] While many factors influence the over-representation of visible minorities in the criminal justice system, Canada's punitive and the discriminatory application of drug laws play a substantial role.

Nations around the world began abandoning the War On Drugs in the 1990s as it contributed to human rights violations and the "spread of infections (e.g. HIV)..., damaged environments and prisons filled with drug offenders convicted of simple possession."[59(para1)] By contrast, up until 2016/2017, Canada continued to develop and enforce prohibition-based drug laws;

however, such laws were publicly, politically, and legally challenged during this time, and periodic allowances were granted. For example, in 2003 Health Canada granted the Vancouver Coastal Health Authority a limited exemption from Canada's drug possession and trafficking laws under the Controlled Substances Act to allow it to open North America's first safe injection facility—InSite.[74] In 2016–17, Health Canada made subsequent efforts to allow for and streamline exemptions to the Controlled Drugs and Substances Act to permit overdose prevention sites (OPS).[75] These allowances, when positioned against the backdrop of over a century of prohibitionist legislation, appear as the first "trickles" in what has become a river of public and political pressure pushing towards decriminalization and legalization of personal possession of illicit substances.

The movement towards decriminalization began to pick up speed in 2016 when the Government of Canada announced a new

Canadian Drugs and Substances Strategy in which harm reduction was re-instated as a major pillar of national drug policy.[63] In 2017 the Good Samaritan Drug Overdose Act became law, providing protection to people who witness drug poisoning events "so that they can seek help, and ultimately save lives."[76(para1)] In 2018 the Justin Trudeau government made cannabis legal for both recreational and medicinal purposes. Canada is the second country globally to accomplish this policy (after Uruguay) and is the first G7 economy.[77] The 2021 development of Bill C-22—an Act to Amend the Criminal Code and the Controlled Drugs and Substances Act—was submitted for First Reading to the House of Commons on February 18, 2021, and has not yet completed Second Reading. Among other things, this bill aims to "repeal certain mandatory minimum penalties, allow for a greater use of conditional sentences and establish diversion measures for simple drug possession offences."[78]

These moves by the federal government towards an anti-prohibitionist stance towards unregulated substances mark a stark contrast to the staunch prohibitionist position taken by previous governments and by governments throughout the 20th Century and into the 21st. Yet positioned as they are against the backdrop of a crisis that has ravaged the nation, taking over 30,000 lives through drug toxicity since 2016, these steps are seen by many as too little, and too late.[79]

2.3.6 Reluctance to Decriminalize

In this report we assume the most common understanding of decriminalization to mean "personal use and possession of drugs is allowed, but production and sale is illegal."[70(p1)] Multiple sectors have asked federal government to do more and move faster in pursuit of decriminalization since 2016. Decriminalization as a policy reframes what has been constructed as a criminal justice issue and positions it as a matter of public health. Decriminalization embodies harm reduction, where people with Substance Use Disorder can access relevant services without encountering the criminal justice system and associated stigma. Under this framework, people found by police to be in position of amounts of illicit substances for personal use are supported with community resources rather than prosecution.[70]

A small group of nations have successfully decriminalized illicit substances. Portugal, through its "radical" 2001 decriminalization drug policy has seen "dramatic drops in overdoses, HIV infection and drug-related crime."[80(para7)] People with Substance Use Disorder in Portugal are understood in society as patients rather than criminals, and they are connected with a web of social rehabilitation and health services. Alongside Portugal, Czechia, the Netherlands, and Switzerland have also decriminalized drug possession for personal use and have invested in harm reduction strategies. The consensus arising from these models is that "decriminalization works."[70,80,81]

The following is a selected timeline of decriminalization initiatives in Canada:

2017 (November): The Canadian Public Health Association report, *Decriminalization of Personal Use of Psychoactive Substances*, calls on the Federal Government to “Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges.”[74]

2019 (April): BC’s Medical Health Officer publishes the report, *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*, and again advocates for federal decriminalization of personal possession.[5]

2020 (July): The Canadian Association of Chiefs of Police report, *Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing Special Purpose Committee on the Decriminalization of Illicit Drugs*, recognizes Substance Use Disorder as a public health issue, and identifies decriminalization for simple possession as an effective way to reduce the public health and safety harms associated with substance use.[75]

2020 (July): BC’s Premier John Horgan formally asked the federal government to decriminalize possession of illegal drugs for personal use.[76]

2020 (November): Vancouver’s City Council passed a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize the simple possession of drugs.[77,78]

2021 (October): BC’s Ministry of Mental Health and Addictions formally applied for a decriminalization exemption, meaning that adults can carry up to 2.5 grams of illicit substances on them without being criminalized.[63,79]

2023 (January): Decriminalization of small amounts of unregulated substances takes effect for all of BC from January 31st, 2023 to January 31st, 2026.[79] While seen by many as progress, the quantity of allowable substances permitted to be carried by an individual is so restrictive, and the progress so slow, that the benefits of this move are seen by many as limited. Along with skyrocketing toxic drug poisoning fatalities, which contribute to a shift in public opinion, these voices are exerting a push against which governments are slowly responding.

Advocates continue to push the government for more substantial decriminalization measures, and they are gaining ground. At the same time, public opinion on decriminalization is shifting alongside the relentless increase in toxic drug poisoning fatalities. Governments are slowly responding to this wider push for decriminalization, but more is needed as fatalities show no sign of slowing.

Some advocating for steps beyond decriminalization, such as the Canadian Drug Policy Coalition does through its Regulation Project, are calling for legalization of illicit substances—a move that would see some currently illegal substances regulated by the federal government in a similar fashion to cannabis, alcohol, and tobacco, making them subject to federal production and distribution laws.[88] Proponents of legalization tout its capacity, beyond that of decriminalization, to establish a system of "regulated purity," enforce age restrictions for sales, "prevent large racial disparities because of the wide discretion in charging by prosecutors," and disrupt "the enormous profits being made from drugs by violent criminal gangs."[89] Some critique legalization for its potential to increase drug use and produce the harms associated with other regulated substances: "We know that currently legal drugs, such as alcohol and tobacco, are widely consumed and associated with an extensive economic burden to society."[90] The argument in favour of legalization is difficult to test as currently there are no countries that have legalized hard drugs.

As a policy initiative, decriminalization represents a proven first step to address the toxic drug poisoning crisis. While this process does little to address drug toxicity or ensure a safe supply of drugs for those who need them, it does free up significant resources in the law enforcement and court systems. Decriminalization treats substance use disorder as a health rather than a criminal justice issue and gives people pathways into the public health system where they might be able to access resources and supports.[83,91] Despite endorsements for decriminalization from the Canadian Association of Chiefs of Police among many other knowledgeable bodies, local governments in BC are using municipal bylaws to take the issue out of the provincial public health realm and into the realm of nuisance. Such bylaws provide police and bylaw officers with new prohibition-based "tools" that they can use against drug users, essentially recriminalizing users at the local scale to advance stigmatization and punitive actions towards people who use drugs. Public frustration with open drug use, and the conflation of harm reduction and safe supply with decriminalization among some city councilors is fueling a retaliatory response against evidence-based policy and governance. This punitive municipal stance against decriminalization is placing some municipalities in direct conflict with provincial jurisdiction. The results of these recent maneuvers are unfolding presently.[83,92–94]

2.4 Upstream Services—Social Determinants of Health

Numerous "upstream services" also contribute to the crisis. Lack of affordable housing, and lack of access to quality mental health services: these are both exacerbating factors. These areas broadly represent the wages of "hypercapitalism" and modern social alienation. The subjects we touch on in the following are by no means a definitive list but represent entry points for systems-based understandings of the crisis.

2.4.1 Housing

The correlation between the toxic drug poisoning crisis and lack of affordable housing is well established. In comparison to household income, house prices across Canada have grown rapidly in recent years—increasing 69.1% between 2007 and 2017, while median income increased by only 27.6% over the same period. Additionally, in the first quarter of 2019, Canada's house price-to-income ratio was among the highest across member nations of the Organization for Economic Co-operation and Development.[95] While Vancouver and Toronto, as global cities, were "the first to catch the bug of extreme housing speculation," the crisis spread quickly to smaller cities and towns. "In British Columbia...it is not only Victoria and Kelowna feeling the heat, but [also] places like Nelson [and] the Gulf Islands."[96] In the Comox Valley, the benchmark price of a single family home was $802,000 as of May 2023, while in May of 2018, the benchmark price was $500,200, an increase of 60% in 5 years.[97] In nearby Campbell River, the benchmark price of a single family home was $646,500 as of May 2023, and was $412,400 in May of 2018, a 57% increase.[97] Housing unaffordability is directly contributing to the exacerbation of health determinates, including homelessness, poverty, and addiction in North Vancouver Island.

"Housing First" is a policy approach that recognizes housing as the most important component in making progress on a multitude of social issues including those related to addiction. This approach has been successfully piloted in Helsinki, Finland, and in Medicine Hat, Canada (AB). As one of the key architects of the Helsinki program observes: "We decided to make the housing unconditional...to say, look, you don't need to solve your problems before you get a home. Instead, a home should be the secure foundation that makes it easier to solve your problems."[98] While the program may appear expensive up-front, it reduces costs related to emergency healthcare, social service, and the justice system, saving as much as €15,000 (over $21,000 CAD) annually for each person provided with housing in the long run.[98,99] A similar program in Medicine Hat, introduced in 2009, has helped 995 adults and 328 children and led to significant progress indicated by "reductions in shelter use, the number of homeless housed and maintaining housing, as well as a number of measures introduced to restructure the Homeless-Serving System."[100]

2.4.2 Mental Health Services

In 2006, Rural B.C. was acknowledged to suffer from a “severe shortage of mental health services”—a reality recognized again ten years later.[101,102] A 2019 BC Coroners Report and a report from the Office of the Provincial Health Officer also confirmed this lack.[103,104] The Province in its 2021 budget committed to providing $500 million in new funding for “expanded mental health and substance use services,” including $152 million for opioid addictions treatment—the largest increase in mental health in the Province’s history.[105,106(para1)] In the 2023 budget, this funding is expanded, allocating approximately $1 billion for mental health and addictions, with over half of the funding slated to expand Indigenous treatment centres, innovate new treatment options, and provide more recovery beds throughout the province.[107] These increases in funding acknowledge both the Province growing gaps in mental health service provision and the link between mental health and the toxic drug crisis.

2.4.3 Hypercapitalism and Poverty of the Spirit

Vancouver-based psychologist Bruce Alexander made headlines with his 2008 book The Globalization of Addiction: A Study in Poverty of the Spirit.[108] Before the toxic drug poisoning crisis in BC gained official status, Alexander posited that the rising proliferation of addiction throughout the 20th century would continue into the 21st. He argued that capitalist forms of growth and accumulation would continue to erode the “social fabrics” that bind communities, families, and societies together. Using Vancouver as an example of an international city whose economic foundations rely upon global trade and the free-market, Alexander shows how the city’s notorious struggle with addiction is a necessary part of hypercapitalism, where the free-market trumps social and ecological health and wellbeing. He argues that the normalcy of hypercapitalism—ubiquitous in cities throughout the globe—is responsible for a mass “impoverishment of the spirit,” including a loss of community and connections that bind individuals together. Alexander posits the importance of belonging and collectively defined purpose as a core human need, one that if left unfulfilled, can result in profound dislocation and attempts by individuals to “fill the gap” through alternate means. When market forces are left unchecked, they lead (in addition to ecological devastation) to widespread social dislocation, and to the proliferation of addiction as a coping mechanism. Alexander’s response to this widespread social dilemma is not to eliminate the free-market altogether and engage in a socialist project. Rather, he asks for better regulation of the free market to ensure it serves, rather than dominates, the institutions and structures designed to foster human connectedness, belonging, and aspiration. Alexander sees such aims as foundational for addressing not only the root cause of addiction but also for bringing people together in profound and innovative ways to address other key crises endemic to our time.

Gabor Maté, a physician and well-known addictions specialist, makes a similar argument. Like Alexander, Maté argues that the roots of addiction lay in a wider societal context, stating that: "...illness in [a neoliberal, capitalist] society, [...] is not an abnormality, but is actually a normal response to an abnormal culture...in the sense of a culture that does not meet human needs."[109] Addiction, mental health struggles, and many forms of physical and emotional distress are in this view a normal response to our failure as a society to acknowledge the consequences of late capitalism. Through a wider perspective, addiction appears as a coping mechanism and response to the absence of cultures of connectedness, belonging, and collective aspiration.

These theorists do not question the role of human agency in the proliferation of addiction. Both acknowledge individuals as interacting differently within the social contexts they are allotted. Some can find connection within late capitalism and others can cope with it. But for a portion of the population, the response to the widespread erosion of the social fabric occurs in the form of addiction (including drugs and alcohol, but also addiction to shopping, gambling, working, exercising, power, money, perfection, others). When unchecked, these habits temporarily fill the void left by a society consumed with free-market logics at the expense of human connection.

2.5 Summary

Our exploration thus far has walked through key dimensions of the toxic drug poisoning crisis beginning with when it was labeled a provincial emergency in BC in 2016. Since then, there has been a dramatic statistical increase in toxic drug deaths nationally, provincially, and locally in Island Health, the North Island Health Region, and the Campbell River and Comox Valley communities. This rise in fatal drug poisoning events is shaped by social determinants of health and processes of late capitalism and has been fueled by several factors including: increased toxicity of supply brought about by a rise in fentanyl production and distribution, over-prescription of opioids followed by an absence of prescriptions which drove many to the illegal market, the rise of the COVID-19 pandemic, and a regulatory environment rooted in a firmly prohibitionist stance. In response, a slate of countermeasures has been developed within Canada and BC to combat fatal drug poisoning events, such as the regulation of safe supply, the use of Opioid Agonist Therapy, the establishment of OPS's, and the relaxation of federal and provincial drug legislation, among others. In addition, there is a growing movement advocating for a new federal regulatory approach to drug enforcement, championed by key advocates such as B.C.'s Premier and the Canadian Association of Chiefs of Police, and there are legislative changes that allowing for decriminalization under a particular set of conditions.

In what follows, we examine the ways in which the drug toxicity crisis impacts NIC staff, faculty, and students. We ask what role NIC is playing and might play in the future in addressing the crisis. We move beyond statistics to look at human stories and human impact, and ask how NIC can spur institutional, systems, and community change.

3 METHODS

The research method we use to produce our findings is rooted in cultural mapping, also known as “deep storytelling.” This method involves collectively listening and reflecting on the stories of those at the heart of the crisis, responding to new insights, and refining grounded recommendations designed to spur policy, systems, and community change. In what follows, we describe this method further and contextualize our use of it.

3.1 About “Walk With Me”

Walk With Me is a community-engaged research initiative developed by research and community teams in the Comox Valley, B.C., in partnership with North Island College, Thompson Rivers University, and Vancouver Island University. The project addresses a toxic drug poisoning crisis that is blindsiding municipal governments and communities, large and small, across the country. In response, the Walk With Me team (which includes Researchers, Peers, Elders/Knowledge Keepers, and Outreach Workers) collaborates with academic institutions, community groups, and harm reduction organizations, bringing together diverse stakeholders to re-frame the crisis through processes of cultural mapping to imagine new ways forward. Adhering to the practice of “nothing about us without us,” our team’s Peer researchers and Elder are involved in every stage of data collection and analysis. By bearing witness to these stories and asking others to do the same, and by putting forward policy recommendations emerging from those at the heart of the crisis, we aim to create the conditions for lasting change.

3.2 Small Cities as Sites of Transformation

Despite differences in their history, geography, and economy, small communities share the common challenge of addressing the health and social welfare needs of their most vulnerable citizens. Such communities are hard pressed to provide accessible social, health, and economic supports found more easily in large urban centres. Those who are socially and economically marginalized, or otherwise require different considerations than the general population, are disproportionately underserved, unheard, and unsupported. Within small communities, vulnerable populations often exist as physically removed from centralized support services in downtown cores. Service

Providers are challenged to reach people in nimble and strategic ways. Frequently small communities also lack key elements within a "spectrum" of care—there may be significant gaps in local care provision services necessitating substantial travel and hardship for those seeking essential help. When crises arise, for instance as related to pandemics, forest fires, floods, etc., the resident vulnerable population becomes further affected, displaced, and dispersed—leading to even more profound issues of care. Walk With Me developed in small cities from within this context, and has identified a particular need and opportunity for innovation in relation to community and systems care frameworks.

3.3 Cultural Mapping as a Core Methodology

Our research practice uses "cultural mapping" as its core methodology. Cultural mapping is a community-engaged research methodology that can help small communities understand the lived and living experience of people facing crises first-hand. Cultural mapping can reveal connections between Peers, family members, and front line Social Service Providers, and between these groups and police, government, policymakers, and the broader public. Having documented and uncovered previously unrecognizable connection, we can articulate new possibilities for response and change. Indigenous communities and community development proponents in the 1990's and early 2000's advanced these research methods, and throughout the last 30 years, the phenomenon of cultural mapping has gained international currency as an instrument of collective knowledge building, communal expression, empowerment, and community identity formation.[110,111] Cultural mapping combines verbal story and insight sharing with artistic sharing to foster understanding about lived realities.

Our primary method of mapping for this report involved a draw-talk protocol, wherein participants drew about their lived experience, and spoke to their drawings, while engaging with researchers in semi-structured interviews. A secondary layer of cultural mapping is built into the project, wherein groups of individuals who listen to the stories given during the primary research phases are invited to respond in turn with their own thoughts and insights. These secondary insights are recorded and form a new "tier" of research. Walk With Me has been conducting this "secondary" cultural mapping research in Island Health over the past two years and has applied the same strategy in our work with North Island College. This method adapts to and foregrounds the communication preferences of participants who at times use a variety of mediums to communicate elements of their lived experience: for example music, poetry, and photography.

3.4 Partnership Between Walk With Me and North Island College Faculty of Health and Human Services

In 2022, Walk With Me, having received funding from the Comox Valley Community

Foundation, banded together with NIC's Faculty of Health and Human Services to create a branch of the project tailored to NIC. Kathleen Haggith, Dean with the Faculty of Health and Human Services, participated in the Walk With Me Leadership Team since 2019 and initiated conversations around how Walk With Me might be brought into a campus environment. Additional exploration with the WWM Leadership Team occurred regarding the potential of this work to raise awareness within the campus community, reduce stigma, and catalyze new forms of leadership and systems change.

NIC has four campuses located in small communities in North and Central Vancouver Island. At its Comox Valley campus, NIC employs approximately 300 individuals and programs courses for over 1800 students. The Faculty of Health and Human Services, which has grown dramatically in recent years, now hosts over 525 students in programs including Bachelor of Science in Nursing, Practical Nursing, Health Care Assistant, Social Services, Education Assistant, and Early Childhood Care and Education. Many students who graduate from these programs move directly into local health and community care jobs, including jobs within the Comox Valley Hospital, Island Health Mental Health and Substance Use services, and a wide range of community service and education organizations. By bringing the Walk With Me research project to Health and Human Services, the team found an opportunity to bring a program of research and awareness to a key demographic entering into the local health and human service fields.

3.4.1 Research Program

Specific to this research program, the NIC Health and Human Services staff team raised awareness of the initiative and aided the WWM Team with participant recruitment, inviting students, faculty, and staff members into the project as Research Participants. This team also helped host the work on site at NIC and collaborated with the Walk With Me team to manage the administrative and logistical details attached to our work.

Research included a series of 2-hour sessions between March 2022 and March 2023 at NIC's Comox Valley campus. A total of 19 sessions involving 220 participants were hosted outdoors in a 20 x 17-foot tent on the campus grounds—sitting in circle, often with a fire pit in the centre. This method of hosting allowed us to foreground the human voices at the heart of our work. Chairs were set up for groups, and the average group comprised of 10 participants. Sessions were open to NIC students, faculty, and staff connected to the Comox Valley campus. In each session, participants were introduced to the project aims and components. Participants were taken through a verbal consent process, and asked to sign a consent form, where they were given a range of options in relation to the use of their insights and verbal contributions.

Having been introduced to the research and having undertaken the consent process, participants were invited to physically "walk with" our team on a guided audio journey, a "Story Walk." Groups were led by our team through forested areas, parks, and through the campus grounds while listening to curated audio tracks featuring Peer voices collected in the primary phase of our research. While walking, participants allowed these voices to "wash over them." Static listening options were in-place for anyone with mobility concerns. Upon completion of the walk/audio track, participants were offered a bowl of soup, and invited to participate in a sharing/research circle. In circle, participants reflected on the audio journey they'd experienced, and were invited to respond to the following research questions:

- How can NIC better support people within its community at the heart of the toxic drug poisoning crisis?
- How can NIC better support students entering a world where the crisis is raging?

Where consent was given, participant responses were recorded. To end the session, researchers reminded participants of the importance of self-care and of the resources available (including NIC counseling services) should they find the stories eliciting strong emotions.

This process of hosting, listening, and sharing was repeated for each research session. In addition, with each session, the act of collecting data was intertwined with acts of service and education. Those attending the research sessions received learning from others in the circle and from the audio tracks. Attendees in turn shared their own stories, insights, and lived experiences, an act that contributed to a "circular" modality.

Audio data from the sessions was transcribed and coded using NVIVO qualitative data analysis software. Key insights and recommendations were identified from this coded material and woven into this report.

3.5 Project Objectives

Key objectives of this project include:

- Cultivating NIC's leadership role in responding to the toxic drug poisoning crisis, given the institution's commitment to enhancing the health and wellbeing of faculty, staff, students, and the wider community.
- Enabling NIC to better support members of its community (faculty, staff, students) impacted by the toxic drug poisoning crisis.
- Enabling NIC to better equip and educate students (particularly those entering careers with high levels of interaction with the toxic drug poisoning crisis, such as Health and Human Services and Trades) on the crisis, including knowledge of the harms of the stigmatization of people who use drugs and awareness of potential pathways for crisis resolution.

- Conducting research with all levels of personnel at NIC to better understand the systemic strengths and barriers at play within the institution in its approach to the toxic drug poisoning crisis.

3.6 Limitations

There are two major limitations associated with the research in this report. First, the nature of the team's interaction with NIC students, faculty and staff was brief in that students were recording key insights as they sat in-circle. In this format, response time was constrained, and those who might have spoken for longer may have felt (given the need to afford everyone in the circle an opportunity to share) that this context limited their sharing capacity.

A second limitation relates to the emotional density of the stories. The act of listening together to stories of lived experience often resulted in alliances and solidarity being built between those who attended and participated in the project and the Walk With Me team. As participants were invited to share their perspectives on the situation immediately following the walk, this connection is manifest in the findings. For instance, a strong and persistent finding calls for Walk With Me (and similar experiential pedagogies) to be brought into multiple areas of learning and sharing within the college environment. While this finding was evident across multiple sessions, it may have been influenced by the immediate feeling of solidarity participants felt after engaging in an emotionally rich and intense experience. We present these limitations for consideration alongside our recommendations.

3.7 Conclusion

In the first three chapters of this report, we have outlined the history and context surrounding the toxic drug poisoning crisis as it has unfolded in B.C. in recent years, and the research methods we work within. These chapters provide a foundation for the Findings section to follow, in which is revealed the key insights that emerge from our research over the past two years with NIC faculty, staff and students.

4 FINDINGS

The findings in this report stem from recorded research sessions with over 220 faculty, staff, and students connected with NIC's Comox Valley campus. Of the 220 participants, 161 individuals elected to be recorded in our research. The following chapter identifies key insights emerging from these recorded sessions. Insights reference many of the concepts outlined in the Context chapter, and present pathways forward for NIC to work to address the crisis, both within its own campus community, and in its relationship with the wider Comox Valley community.

As we launch into these findings, we want to honour and acknowledge the participants who boldly gave their stories and insights. Our team is honoured to have received these—they were given with immense courage and with intent to spur change. Our circle has borne witness to these stories/insights, and we ask those who read them to do so with respect, acknowledging the impact of this crisis on individuals, families, and friends, and the need to come together towards the formation of new ways forward.

4.1 The Crisis is Here in the Comox Valley

Throughout our work at NIC, our team was struck by the extent to which NIC faculty, staff, and students are impacted by the toxic drug crisis—both on a personal and professional level.

Of the 161 individuals who gave their voices to this research, over 21% indicated, without direct prompting, that they had either experienced the toxic drug crisis in their own lives or in the lives of family and friends. Many spoke to their roles in providing regular support to people who are using or have used unregulated drugs. Given the fact that these accounts emerged indirectly, we wonder how many more accounts remain unspoken. In what follows, we share a handful of participant insights (out of many) that we feel capture the essence of these accounts.

Many participants had shared how their own lived experience of the crisis affected their lives directly:

I've personally battled addiction in my youth for many years. So it was part of the drive that sent me into nursing, just knowing that level of stigma and misunderstanding and just feeling so much shame and hiding from the world.

(Deidentified Participant)

I was another one of those stories that just started out at a young age because I didn't like who I was and how I felt, and progressed…I had to go to treatment four years ago…I came out, and I was good for a few months, and then got into the old things and another six months. And I've been clean for two and a half years as of yesterday.

(Deidentified Participant)

I started with marijuana and then I progressed to cocaine, and that was like a 10–12-year thing. You know, it doesn't get real until there's just that moment of helplessness. And you're just at a loss, like who do I talk to? I was raised in a Christian family… And they treated me well, so I was supposed to be that kid that made it you know? And I just, and I didn't…

(Deidentified Participant)

Other similar first-hand accounts were shared in session, drawing attention to the ways that the crisis directly impacts students, staff, and faculty. Additionally, many spoke to the crisis' impact on their families and friends:

This hits really close to home to me because I have someone close to me that has experienced and is experiencing addiction. And I'm very close within their support [network].

(Deidentified Participant)

I have a family member who struggles with addiction and who doesn't know how to reach out for help.

(Deidentified Participant)

I have witnessed it firsthand, mostly through the eyes of my ex-girlfriend who was heavily influenced with drugs. And earlier this year, I lost a former friend of mine to drugs…

(Deidentified Participant)

Numerous participants spoke to the roles they play or have played in supporting people who use substances. These stories spoke to often-heroic ways in which students, staff, and faculty are showing up and taking care of friends and family members—including through detox, grief and loss, mental health episodes, and more. Participants conveyed the often-hidden emotional toll being paid by those who assume a caregiving role for people struggling at the heart of the crisis.

While a significant number of participants shared stories related to the crisis' impact on their personal lives, others spoke to the ways in which the toxic drug poisoning crisis has unfolded in their professional environments:

> **I started years ago in early child education...Unfortunately, I have lived experience with losing a young parent and her partner through the toxic drugs, and her two children are orphans now. So I think about them a lot. I think about where they are today, I think about how senseless the loss of their parents [was].**
>
> *(Deidentified Participant)*

This story illuminates the long-term trauma that can be attached to experiencing direct loss in the workplace. We received many such stories, in addition to stories that acknowledge the ethical complexity that the crisis has produced within the workplace—where many experience frustration with the brokenness of support systems:

> **I currently work in emergency as a nurse, as an LPN. And, you know, I've had patients leave that, based on my assessment...I wasn't allowed to let them leave. So I've had to put out warrants and call the police on them. And, you know, [many patients] already have a distrust of the police. I don't know if that's really like, helpful. I...wish our emergency services would have another aspect to it other than just police, fire, and paramedics, I wish we would have like, social worker, nurse team, or something like that.**
>
> *(Deidentified Participant)*

Such accounts illuminate some of the workplace difficulties emerging in the wake of the crisis. In health and human services professions, in particular, employees are struggling with unprecedented levels of loss. They are also dealing with a wave of patients who are under-supported within current systems of care, and whose already-complicated life situations are exacerbated by the realities of addiction and homelessness.

Several participants spoke to how the crisis is impacting the NIC Comox Valley campus community specifically. The following is an account of a toxic drug poisoning death that took place on-campus:

> Recently, we had somebody who overdosed and passed away on our property here...I was in a meeting. And we were all, you know, kind of in shock...it was a couple of months ago. But... this is what's happening everywhere...The sad thing is, this isn't unique, but we were all feeling like this was—this has never happened at North Island College before. But it's...the reality.
>
> *(Deidentified Participant)*

Such accounts present an array of intersections with the toxic drug crisis experienced by members of NIC's Comox Valley community—through a personal lens, a family lens, a workplace lens, and a campus lens. Such insights, coupled with the recent statistics we have shared in Chapter 3, show the rising impact the crisis is having in the Comox Valley, and dispel the myth that the crisis is "happening far away." As such, the crisis has a profound and tangible impact on the NIC community, requiring a meaningful and significant response. The extent of the grief and loss experienced by students, faculty, and staff invites questions related to the institution's current and potential role for supporting and "holding" people who are struggling, and in providing access to relevant supports. This crisis is here, it is pervasive, and it is experienced deeply. In the next section we further draw on our participants' reflections to begin to outline some actions that might be taken by NIC to support the campus community it serves.

4.2 Harm Reduction

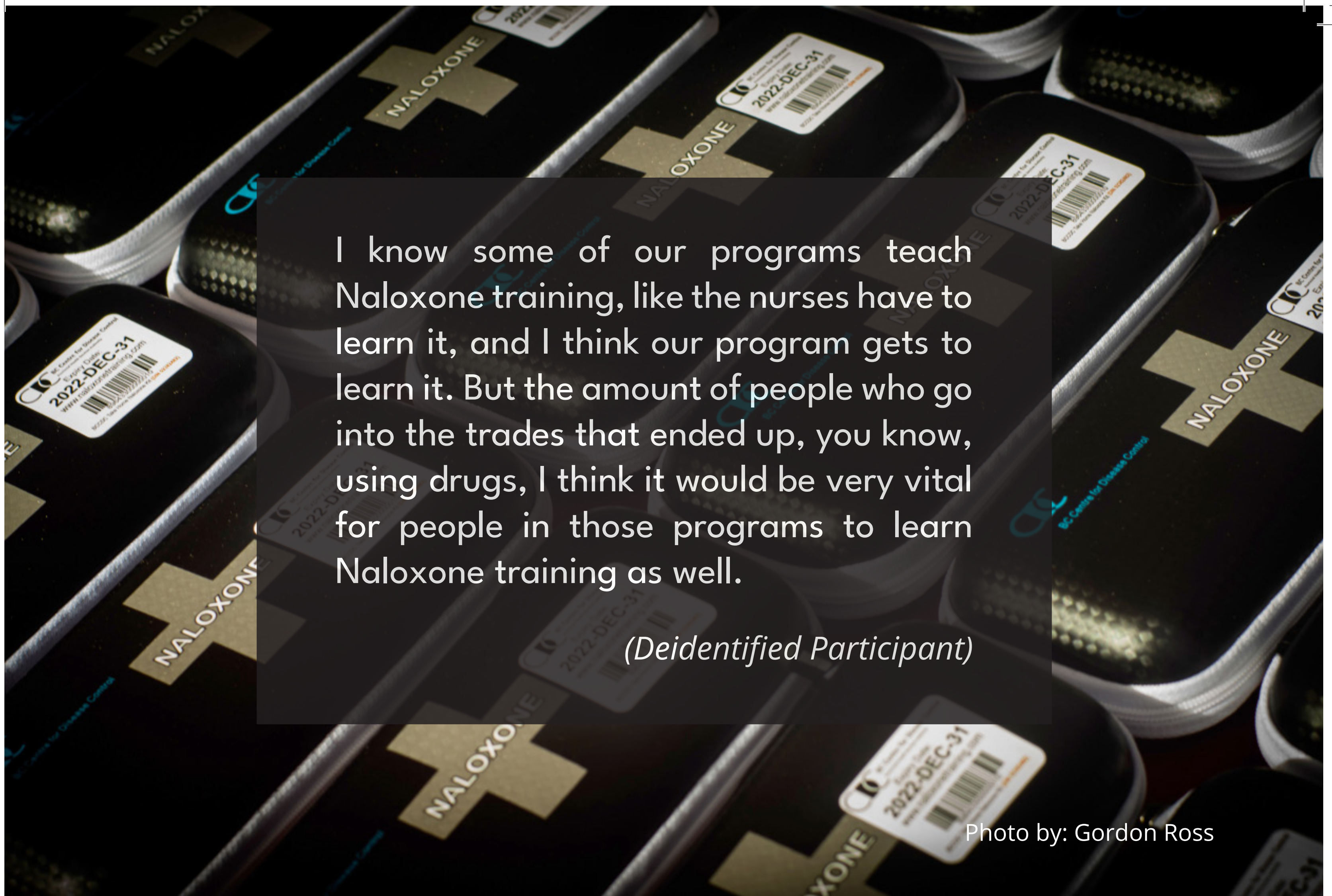
Recognizing that the crisis is here, the next section addresses the research question: How can NIC better support people within its community at the heart of the toxic drug poisoning crisis? This question references NIC's internal role as an employer and educator committed to the health and safety of its students, faculty, and staff, while also exploring how the College can build and expand its existing services and supports for those within its internal community.

As a starting point, there are many services and supports already in place on campus at NIC, and many were identified as providing benefit to students. Participants reflected on the supports provided within the institution's counseling services (free and widely accessible to students), including within its community referral practices. Further, the Student Union is recognized for its role in providing emergency funding, as well as advocacy and support for students experiencing crises, and the Elder-in-Residence program is also recognized as providing culturally sensitive support. Recognizing these strengths, several key areas were flagged as opportunities for service expansion and/or development.

4.2.1 Basic Harm Reduction Services

On a basic emergency response level, some participants expressed a need for the expansion of Naloxone training and drug testing on campus:

> **I know some of our programs teach Naloxone training, like the nurses have to learn it, and I think our program gets to learn it. But the amount of people who go into the trades that ended up, you know, using drugs, I think it would be very vital for people in those programs to learn Naloxone training as well.**
>
> *(Deidentified Participant)*



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(Deidentified Participant)

Photo by: Gordon Ross

> **I do know that they do Naloxone training sessions here every now and then. But they're quite far and few between and pretty small windows of time.**
>
> *(Deidentified Participant)*

> **The OPS site in the valley has fentanyl testing strips and stuff. It'd be nice to have that on campus as well for people.**
>
> *(Deidentified Participant)*

In addition to bolstering already-existing training and services, participants flagged the need for a student-led outreach team that supports people on-campus (and potentially off as well), struggling and/or during this crisis:

> **Create some sort of outreach team that students from any program, any NIC student could volunteer to almost do like shifts...give us the opportunity to go out into the community and do some of this outreach work along with training with Naloxone, which we've done as nursing students...**
>
> *(Deidentified Participant)*

Such an initiative would need to develop with strong confidentiality protocols. It was recommended that such a service be

structured to provide at least some level of anonymous support to people to minimize potentials for unwanted disclosure:

> **That fear of going and then having your peers and, you know, fear that they would say something outside of that safe zone…I'm not sure if something like online or virtual would be more accommodating…**
>
> *(Deidentified Participant)*

These insights present the need for an increased array of harm reduction services on-campus, including naloxone distribution and training, drug testing, and outreach services. Recognizing the levels of stigma that continue to persist, we also see a need for confidentiality protocols to be embedded within these services.

4.2.2 Harm Reduction Training for Instructors

Alongside the call to bolster NIC's harm reduction services is a call for harm reduction training for instructors. Participants perceive an increase in the number of stressful life circumstances that students are experiencing (including but not limited to toxic drug-related circumstances), and a corresponding expansion of instructors' roles in supporting students in crisis:

> **There's so much pain. And so deep pain. And I guess I see that in my students, you know, some people arrive in our program, and we can tell, there's just all that stuff.**
>
> *(Deidentified Participant)*

> **We deal with students every day. And we see them through their stress and their anxiety and their depression and their lived experience of being in school, but also dealing with, you know, their lives and their work, and their, you know, all the things that they put on top of school. And I just feel like this last couple of years have added a whole other level…**
>
> *(Deidentified Participant)*

> **I think of the heroic kind of struggles, and I don't use that word lightly, if someone emerging from or adjacent to this crisis made it into one of our classes…I know, if I was still an educator, I wouldn't be prepared to help in the way I should be. And I think that's something we have to really think about.**
>
> *(Deidentified Participant)*

Participants highlight the importance of preparing instructors to recognize the signs of students struggling with the toxic drug and related crises, and they asserted a need to equip educators with tools, methods, and approaches that foster safe spaces and connect students with relevant harm reduction resources. Further, participants saw the act of training instructors in principles of harm reduction as a way to combat stigma and create a culture conducive to systems change.

4.3 Creating Culture Change

Beyond bolstering essential training and resources related to harm reduction and equipping instructors with harm reduction

tools and training, many research participants identified the need for culture change (at-large) on-campus. Participants felt that such change involves awareness-raising initiatives that include dialogue and reflection in order to counter stigma and generate systems-based transformation. Participants responded to their recognition of the pervasive stigma within the college environment:

> Destigmatizing is definitely at the top of the list of the things that need to happen [within NIC].
>
> *(Deidentified Participant)*

> **There is so much invisibility in this community of ours here about addiction, homeless[ness]; the stigma is still rampant.**
>
> *(Deidentified Participant)*

Many participants identified a need to actively address this stigma and to create opportunities for new and progressive forms of understanding and to cultivate action.

4.3.1 Creating Safe Spaces

Part of the work of creating culture change involves creating "safe spaces" and experiential learning opportunities where conversations about substance use and supports are normalized and supported. As participants told us:

> **Yeah, safe spaces, having more conversations, normalizing conversations, you know, destigmatizing conversations...**
>
> *(Deidentified Participant)*

> **I think the more that we talk about something, we reduce the stigma around that. And the more that we are aware, as a community...as students and in our lives that these problems exist, we can be aware that this could happen to anyone...**
>
> *(Deidentified Participant)*

> **I think what is needed is more conversations, you know, offering a safe space removing the stigma and also stereotyping...I think that's very important.**
>
> *(Deidentified Participant)*

Participants see the creation of safe spaces for sharing and reflection as an active exercise that requires deliberate effort on the part of the College:

> **Building in...the time and space to reflect and to share. And it's in the sharing of ideas, I think, that other things emerge. So how do we navigate that institutional, structural, governmental conflict, to actually carve out deliberate time to reflect, to integrate, to share, to grow, to emerge, to develop?...**
>
> *(Deidentified Participant)*

Building in...the time and space to reflect and to share. And it's in the sharing of ideas, I think, that other things emerge. So how do we navigate that institutional, structural, governmental conflict, to actually carve out deliberate time to reflect, to integrate, to share, to grow, to emerge, to develop?...

(Deidentified Participant)

Photo by: Sharon Karsten

This articulation of a need to build safe space emerged consistently and across multiple sessions, and many participants see this as a fundamental step in a journey towards building wellness within the NIC campus community.

4.3.2 Practicum Placements

NIC is currently creating safe spaces through the Faculty of Health and Human Services practicum and practice courses. Research participants identified this requirement in the Health and Human Services programs (which places students in community health and harm reduction employment settings for limited time-periods) as a valuable venue for learning, growth and development, where students form relationships and connections with people experiencing the crisis first-hand. The following participant quotes reflect the value of this learning opportunity:

> **I had the opportunity to be at Kwesa for my last practicum, and it had more impact than, you know, anytime I've spent in the hospital so far, just because, again, it's that humanization of people and just sitting and chatting and really learning that trauma is the basis for all of these issues that we see people having, and so I'm having my practice going forward being very trauma informed.**
>
> *(Deidentified Participant)*

> Throughout my time I spent at a homeless shelter, I got to know a lot of people on a very human level, you know, I got to know who they were as people and what they liked and what their stories were...I always find myself looking back on those people that I knew and finding that human connection come up again when I see anyone suffering in those same situations. And so I think that any way that NIC could find ways to bring these people to us could really humanize them in a lot of people's eyes.
>
> *(Deidentified Participant)*

> **I had an opportunity to have a placement at a local warming center, which was way more applicable than any of the single textbooks that we have read through, or the seminars that we've had discussing people with these experiences, because you actually get to have conversation and find out who these people are.**
>
> *(Deidentified Participant)*

Recognizing the value of practicum placements rooted in community harm reduction contexts, some spoke to the need for the College to secure more of them:

> **A way that NIC could help us gain more knowledge and be a little more involved will be in securing preceptorship placements for us within mental health and substance use. There's been very limited placements for us.**
>
> *(Stevie Hunt - NIC Nursing Student)*

> **I think that these experiences are really important and will help us all become better nurses. And I think that NIC does a good job of trying to find as many of these experiences as they can. And, you know, there's always room for more.**
>
> *(Deidentified Participant)*

> **[NIC could be] connecting us with community resources and how we can be involved and how we can build those connections because I don't know where to start from.**
>
> *(Deidentified Participant)*

Clearly, practicum opportunities in the Health and Human Services programs are helping bridge the divide between the college learning environment and the realities of people involved in the crisis. NIC needs to continue to work to enhance its placement opportunities and build on their network of existing safe spaces.

4.3.3 Peer Mentorship and Teaching

Participants suggested integrating Peers into the college environment as teachers and mentors to promote another method of creating safe space:

> **We always talk about education, education, education, we need a class, we need more information. But...it's like we just we want to spew out information and how much does that really help?... When you come to know a story, or you come to know a person, having them in the classroom, or having them as a guest speaker...I think that personalizes it, and it makes it more accessible, and we relate.**
>
> *(Deidentified Participant)*

> **What I found most impactful from my first year was when we had some people coming into the class and speaking with us on their own experiences, face to face. And that's something that I won't forget.**
>
> *(Deidentified Participant)*

Participants place an immense value on building safe spaces, first through opportunities for dialogue (broadly) in

relation to the crisis, then through the development of harm reduction-based community practicum placements as well as Peer teaching and mentorship for experiential learning. Within these actions, safe spaces are generated and enhanced that exist beyond a standard or confined classroom learning protocol; they foreground the wisdom of lived experience and grounded knowledge.

4.3.4 Walk With Me

A significant number of students (over 45) expressed a desire for Walk With Me sessions (or similar projects) to be offered at the College on a long-term, campus-wide basis. In Chapter 3, we encouraged a level of critical reflection regarding this recommendation, recognizing the desire as emerging in-part from within the context of the emotionally charged experience of participating in a Story Walk. Acknowledging this reality, and the problematic nature of assuming a celebratory approach to our own work, we felt it important to include this finding nonetheless as it was voiced persistently. The Walk With Me program was valued by participants as a safe space for dialogue and conversation. Participants appreciated the model of centering Peer stories and leadership while supporting conversations for long-term change:

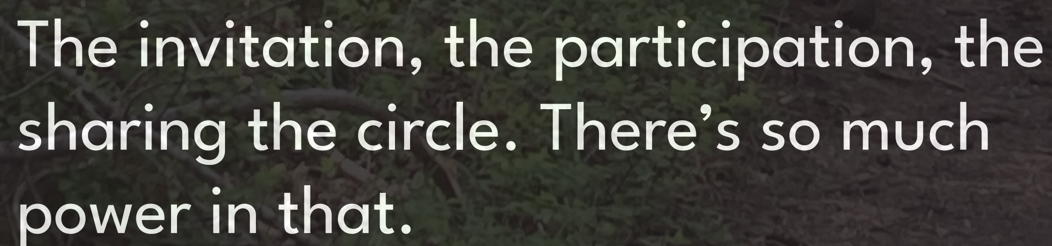
> **I hope that this [Walk With Me] opportunity for students, faculty, I hope it continues, for as long as long as needed. It's just very valuable and impactful. And hearing people's stories is way more important than reading a textbook about this, in my opinion.**
>
> *(Barb McPherson - NIC Faculty)*

> **I think every HCA student should have come to [Walk With Me], like, why in the heck didn't we all do this?**
>
> *(Deidentified Participant)*

> **I think that every administrator at North Island College and instructors need to participate. There's a lot to process.**
>
> *(Deidentified Participant)*

> **The invitation, the participation, the sharing the circle. There's so much power in that.**
>
> *(Danielle Hoogland - NIC Faculty)*

These comments reinforce the previously identified need for safe spaces and for developing increased connectivity between students, staff, faculty, and a wider community of voices. Walk With Me is one model for experiential learning that helps create conditions for long-term change, one that can, and should be combined with other methods and models that respond to the toxic drug poisoning crisis.



The invitation, the participation, the sharing the circle. There's so much power in that.

(Danielle Hoogland - NIC Faculty)

Photo by: Sharon Karsten

4.3.5 Summary

Our team was honoured to receive insights from faculty, staff, and students that relate the gravity and impact of the crisis on-campus, outlining key challenges and opportunities. We received insights flagging the need for more lifesaving services on-campus, including Naloxone training, drug testing, and outreach. We also heard about high levels of stigma on-campus, and the need for safe spaces to cultivate change and learning. Perhaps most importantly, we heard about some key pathways forward in addressing the crisis, such as equipping instructors with harm reduction knowledge, expanding community-based harm reduction practicum opportunities, creating spaces for Peer instruction and leadership, and continuing the pedagogical and research model explored by Walk With Me. These pathways combined are progressive steps forward for the institution to address the crisis.

4.4 NIC and the Outside World

Beyond NIC's role in directly supporting students, staff, and faculty, participants also identified how NIC can better support students entering a world where the crisis is raging (our second research question). Here, those we spoke to recognized the importance of building reciprocal connections between NIC and the local community to bring new forms of relevance to NIC's curriculum and student learning. They also recognized that it was NIC's ethical responsibility (as an institution responsible for developing the next generation of care workers in the Comox Valley) to work collaboratively with a range of community partners and to contribute its own resources towards the development of viable community-led solutions:

> I think as an organization so closely linked, ideally, with community, we do have a role to play in trying to determine a solution for our communities. I think it's a big part of our role if we have the capacity to do it.
>
> *(Deidentified Participant)*

How can NIC be with community?… [There is a guiding document that says] this is what NIC does. And it references community…but making room is such an awesome responsibility. I don't think we've even touched it…I am working…with a large committee, a community engagement strategy draft, and…part of that drafting process is to get that out there to organizations that maybe wouldn't typically be part of the consultations.

(Deidentified Participant)

Participants walked us through several different strategies for increasing NIC's connective role, including reducing education barriers for peers, developing an on-campus harm reduction and services hub, and reducing or eliminating hostile architecture. We outline these strategies next.

4.4.1 Reducing Education Barriers for Peers

Participants saw NIC as having a role to play in making its education and career development programs more accessible for people at the heart of the crisis. Increased accessibility, here, includes reducing financial barriers, housing barriers, and red tape involved in applying to College programs, while increasing incentives and support for people at the heart of the crisis:

> **Give people…a good place to start…A lot of people are just like, "Oh, it's so easy to apply for jobs…" but how are you going to apply for jobs when you're carrying back packs on your back, you look grubby you know, it's just like you need to give people like a place to start and help them you know; they can't get there on their own, and I think a lot of things need to change.**
>
> *(Deidentified Participant)*

> **Increasing incentives, support, and financing for people to be able to access post-secondary education, [providing] really accessible application processes, and access to upgrading and education that's required to get into programs.**
>
> *(Deidentified Participant)*

It is important to recognize the numerous services that are currently in place at the College, including initiatives that support financial aid, student employment, access to health and dental benefits, and provincial supports for former youth in care, among

others. However, many participants thought more was needed to reduce barriers to entry for those struggling with substances, and/or living unhoused. Such a move might, in our team's view, involve "supported education," where participants with a history of Substance Use Disorder are provided with low-barrier access to education, alongside a range of additional supports such as outreach, harm reduction, safer supply, OAT therapy, housing, etc. Education, in this scenario, becomes one more "wrap around service" that enables participants to pursue wellness, build skills, and create a better future. Participants see that reducing barriers within the College is a powerful move that would support and nourish those at the heart of the crisis, enabling culture change within the student body at-large.

4.4.2 Developing an On-Campus Harm Reduction and Services Hub

Several participants highlighted the need for NIC to work towards a more supportive campus environment, where people who use drugs and who live in the wider community (i.e. not necessarily students, staff or faculty) feel welcome. Here, participants recognized the College campus can feel alienating to outsiders. They also noted NIC's geographic proximity to the Comox Valley Hospital and Aquatic Centre, and the notion that this "triangle of institutions" could work together to explore and create a "social innovation resource hub" which could support people at the heart of the crisis:

> **Working with, you know, our upcoming housing development and working with the Aquatic Center, and the hospital and...this fabulous little campus of resources that we have here on the corner of the hill, [services] could really expand...I think a way that NIC could support individuals, some...really tangible things in response to the stories shared, such as external outlets, and access to water, and washrooms, and community showers, and all of those things.**
>
> *(Deidentified Participant)*

Such a hub could link into the College's student residences (currently under construction), providing harm reduction resources and supports on campus for the wider community. In our team's view, this hub could respond to many of the needs identified in this report by:

1) generating additional practicum placements for students;

2) serving as an operations centre for a student outreach team;

3) providing classroom space for supported education;

4) acting as a safe space where anti-stigma training can be provided; and

5) supporting connections between the campus and the larger community while generating social justice and innovation.

Our team is inspired by this "hub" concept and believes such an initiative would help equip students with the knowledge and

skills to enter a workforce where the crisis is raging, while also positioning NIC as a leader among campuses in its commitment to social innovation. However, for such a hub to succeed, changemakers need to listen deeply to the wisdom of local harm reduction service agencies and Peers—to better understand needs and the unique set of potential challenges and opportunities involved.

4.4.3 Reduce/Eliminate Hostile Architecture

Some of our participants drew attention to NIC's architectural structures (buildings, parking, landscaping, etc.), and asked how NIC could create a more welcoming and hospitable environment within its physical layout. These explorations involved a sense that the campus was "removed" from the wider community and a desire to increase the porousness and integration of the campus with underserved communities, including Peers.

> One thing I think NIC could also talk about more is hostile architecture and why hostile architecture exists in the first place. And what it is meant for, I think a lot of times, we walk by things like that, like planters and such outside, and we don't think anything of it, when in reality, there's a reason behind why they're placed there, and it's not necessarily a good one.
>
> *(Deidentified Participant)*

Photo by: Sharon Karsten

One participant suggested creating an accessible charging station for phones, etc., as an example of a compassionate architectural improvement.

> **Where do you go? Where do you plug in your phone?...One morning, I arrived here a few months ago, and a man was in a power chair parked outside the door, and I was quite early... So I was like, oh, nobody's here yet. Making an assumption he was coming for an appointment. But he said, "Oh, no, that's okay. I made it up, Ryan [Road]. And now I'm just plugging in. ... And I thought, "oh, stupid me." Right. Like, of course, there's a plug there. People could be using that; it's a publicly funded building.**
>
> *(Deidentified Participant)*

Participants suggest that campus structures and services should be evaluated with an aim to create more welcoming spaces. Such spaces should welcome people outside the campus community, including underserved communities, people who are unhoused, and people who are struggling with mental health and addiction, and support them through access to the College's buildings and infrastructure.

4.5 Changes to Curriculum

In Section 4.4, we outlined a key and pervasive call for NIC to create stronger linkages with local community agencies working on the toxic drug poisoning crisis—a move seen to bring the "outside" world closer to NIC students and bolster the relevance of the College's work and contribution to community. As our participants suggested, supporting such work might involve transforming the ways that students are taught to interact with and support those on the front lines of the crisis. Some expressed a call for NIC, and in particular the Faculty of Health and Human Services, to examine its core curriculum with the intent to better-equip students with the knowledge and skills needed to enter into workplaces that are blindsided by the crisis. Many care systems are currently experiencing a "shock" while attempting to address the crisis and its impacts.

> In nursing...we know that our students are entering in [to the system] as new graduates and feeling vulnerable and will compromise their values in order to fit in, to connect, to feel like they belong, and turn a blind eye and sit with that distress.
>
> *(Deidentified Participant)*

I've cried out of anger towards our system, and the people that they get forgotten about. I've done lots of volunteer work with the Homeless Coalition... And it's heartbreaking there. The system sucks. Essentially, it really sucks.

(Deidentified Participant)

Participants called for an evolved curriculum to better prepare them for the challenges they will face within these systems. Such a curriculum would build resilience in the face of stigma and allow participants to make valuable changes within systems that are struggling to adapt:

> **I think a lot of it comes down to education. And it comes down to things like this [Walk With Me]... This is my third year with the healthcare assistant program. And this is the first time we've gotten to do something this informative, and just really, into the, you know, the nitty gritty of [the crisis] for lack of a better term...we teach about it, and we talk about it, but there's only so much that, you know, from a textbook that you can learn.**
>
> *(Deidentified Participant)*

Participants see the act of revising the curriculum (and its delivery) to better address emerging realities within the health care system as an act of progressive future-making. NIC is recognized for its potential leadership role in equipping next-generation health care workers to enter broken care systems as critical thinkers and changemakers:

> **I would like to just rebuild it. How do we do that? How do we get everybody on board?... The starting place is the conversations, and recognizing where the deficiencies are... From [the] North Island College perspective, we have the future here, right, and those future leaders that can help make that change.**
>
> *(Deidentified Participant)*

By equipping students with critical and equity-based grounding, students can successfully contest the injustices in these systems, and NIC can help produce next generation leaders who refuse to settle for the status quo. But such transformational change in curriculum cannot happen without also making the bold step to Indigenize curriculum, to meet Indigenous students where they are at, and equip them to face unique challenges.

4.5.1 Indigenize Curriculum

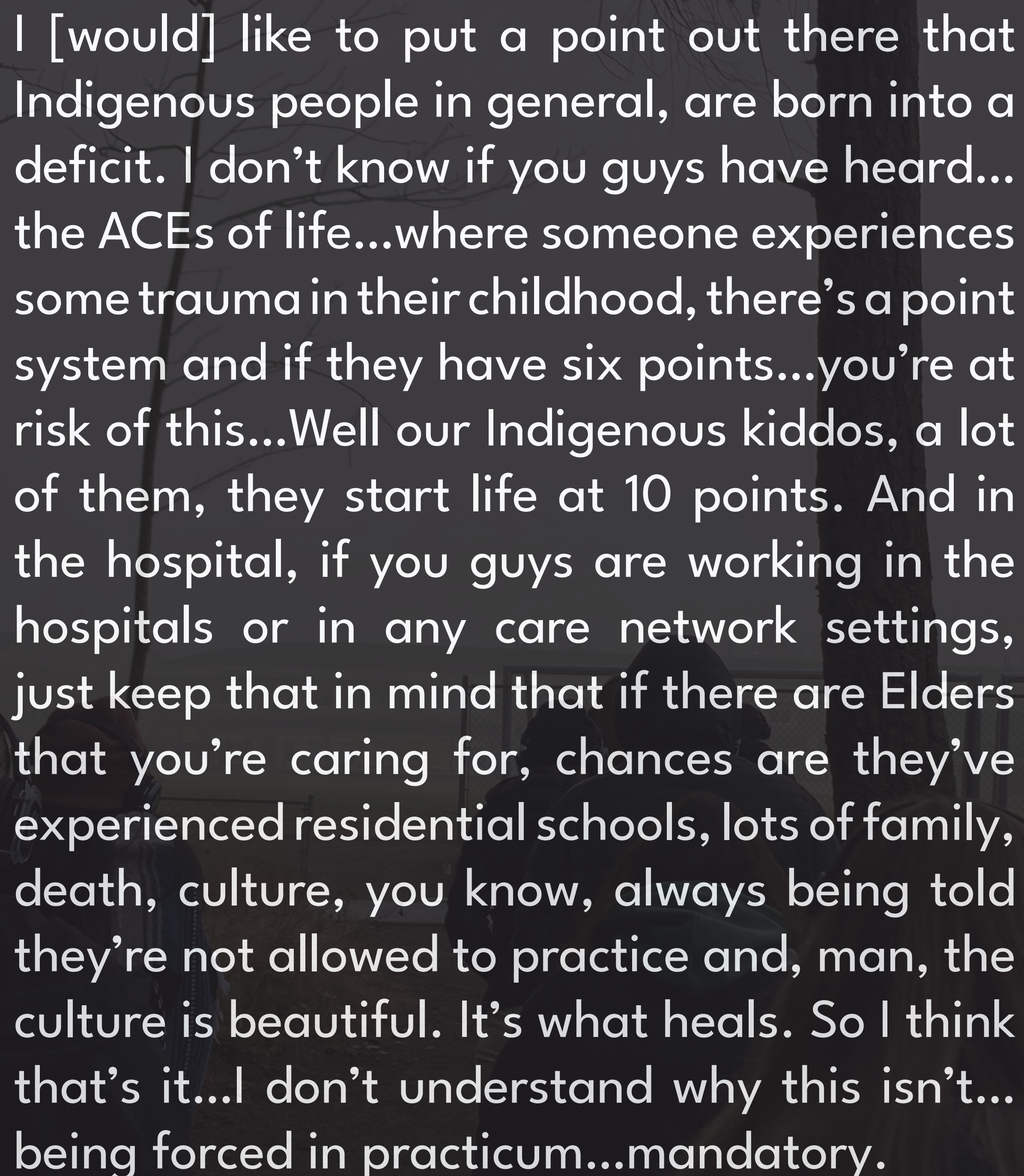
One final but important insight arose in relation to how NIC might better-equip students to enter the workplace in the midst of the crisis. Participants observed the over-representation of Indigenous people at the

heart of the crisis, and the need to create spaces for cultural safety, cultural belonging, and cultural learning and sharing as a form of harm reduction:

> **If [we] can make voice[s] heard…[if we can] Indigenize the education stream…it might give [us] a better perspective of challenges that Indigenous people face daily due to colonization.**
>
> *(Deidentified Participant)*

> **In terms of the curriculum design…Indigenizing the curriculum and having real stories and simulated events for overdose crises and how would you react? What is the critical thinking behind how you will respond from a healthcare providers point of view?...I think you have to strive for excellency in educating and making safe opportunities for the students to learn about students who may be suffering from childhood trauma.**
>
> *(Deidentified Participant)*

For many participants, Indigenizing education was seen to create space within the curriculum for "other ways of knowing and being," opening new wellness pathways while addressing the rampant hyper-individualism that has eroded the fabric of our communities and social connections. One participant pointed to the ways that Indigenous students are often affected by childhood trauma (or what in the academic literature is called "Adverse Childhood Experiences" [112,113]), and asked why material on the adverse experiences of Indigenous children wasn't being strongly integrated into the curriculum.



I [would] like to put a point out there that Indigenous people in general, are born into a deficit. I don't know if you guys have heard... the ACEs of life...where someone experiences some trauma in their childhood, there's a point system and if they have six points...you're at risk of this...Well our Indigenous kiddos, a lot of them, they start life at 10 points. And in the hospital, if you guys are working in the hospitals or in any care network settings, just keep that in mind that if there are Elders that you're caring for, chances are they've experienced residential schools, lots of family, death, culture, you know, always being told they're not allowed to practice and, man, the culture is beautiful. It's what heals. So I think that's it...I don't understand why this isn't... being forced in practicum...mandatory.

(Deidentified Participant)

Photo by: Sharon Karsten

Participants also valued the move to centre Indigenous ways of knowing and being as a way of generating possibilities within an otherwise bleak landscape, recognizing the important role played by culture and community in combating the crisis:

> **I had this image at the very beginning when you were talking before we went for a walk, and you had said something about how grateful you were, that there was some weaving happening between the different communities. And when you said that, immediately in my mind's eye, I guess I just saw a giant dream catcher. And I thought that that was really cool, because it just came and I didn't call it, and I thought that's exactly—and then when we were walking, I kept kind of having that image and thinking how...dreams get lost, right? And so, the whole sort of thing was keeping them giving them something to catch them and keeping it there for people.**
>
> *(Deidentified Participant)*

Currently, NIC has various efforts with various departments underway to Indigenize its curriculum. As one participant suggested, "NIC could move towards...a fully accredited four-year Baccalaureate in Indigenous focused nursing." Other insights highlight the importance of such an initiative. They call for a centering of Indigenous cultures and teachings to promote understanding related to the harms done to Indigenous people through legacies of colonization, and to recognize the healing power of culture and community.

Together, these insights call for a profound re-thinking of curricula—one that foregrounds the crisis and its impacts and historical roots, and equips students with the critical thinking, empathy, and changemaking skills to not only survive their entry into broken care systems, but to also develop the skills, critical thinking, and resilience to move these systems forward.

4.6 We All Matter

In closing this section, we draw attention to a key insight raised by many participants through the course of our circles, summarized in the phrase "we all matter." This phrase is a recognition of the fundamental humanity underlying all members of our community, and it pervaded our discussions, providing impetus for deep sharing and empathy. Within our dialogues, several participants spoke to the empathy of children, referencing the power of such empathy to root and inform our actions moving forward:

> **I have my little son who will always say hi to everybody. And he really looks at them with his heart and his eyes. And that just really makes me proud, because he's a little different himself. And he recognizes that we're all human beings and we all matter. That was the other piece in the walk that really stood out for me is that we all matter. Like we're all here, we all matter.**
>
> *(Deidentified Participant)*

In thinking of how NIC might better-support people at the heart of the toxic drug crisis, the principle that “we all matter” emerges as an anchor point. Looking out at a care system struggling profoundly to address the new realities brought about by the crisis, and at a sea of faces enrolled at NIC who will go on to take up roles within this system, the principle that “we all matter” is a foundation for leadership and radical changemaking. The question NIC now faces is how to cultivate, enable, and activate this potential.

4.7 Summary

This report, which draws on the insights of over 161 NIC students, staff, and faculty (most from the Health and Human Services Faculty) who gave their voices to the project over a two year time frame, provides a series of research findings to support evidence-based recommendations. We received insights regarding the impact of the crisis within NIC’s Comox Valley campus, including its impact on individuals personally, on their families, workplaces, and on the campus environment. Responding to this impact and reality, participants issued several calls including calls to bolster harm reduction services on-campus, to prepare instructors with harm reduction techniques and philosophies, and to create safe spaces through opportunities for dialogue. Participants also made suggestions to develop additional practicum placements, enable Peer participation in classroom learning, and supporting experiential programs like Walk With Me to function within the college environment on a structural level. In order to better-equip students to enter a world where the crisis is raging, participants asked NIC to increase its engagement with local harm reduction leaders and initiatives and create more safety and harm reduction measures on campus. Such measures include addressing and reducing barriers for Peers seeking education, developing an on-campus services hub, and evaluating architectural features of the Comox Valley campus to create a welcoming environment. Participants spoke, as well, to the need to evolve curriculum to better-equip students to enter and transform broken health care systems, and of the need to Indigenize education, recognizing the importance of equity-based learning to provoke change. Participants recognize the fundamental humanity of those struggling at the heart of this crisis and saw education as a starting-point for community and systems change.

These insights, gifted to the project through many voices and intentions, are powerful in their ability to make change, and in their call for compassionate and radical action. They form the basis of the recommendations that follow.

5 RECOMMENDATIONS

Having sat in-circle with NIC students, staff, and faculty, we now take a step back to ask: How can NIC (Comox Valley Campus) spur culture, community and systems change in response to the Toxic Drug Crisis? As part of this overarching question, we reflect again on our core research questions: **how NIC can better-support people within its community at the heart of the toxic drug poisoning crisis? ... and how NIC can better-support students entering a world where the crisis is raging?**

In asking these questions, we also ask: **who is responsible to make this change?** Clearly, the toxic drug poisoning crisis is complex, necessitating a multi-faceted response. Given this fact, any meaningful solution will require multiple change-agents within and outside NIC to work together towards common goals. The most obvious of these change agents include: NIC leadership and instructors, local health authority leadership, and, less formalized, groups of Peers, family members, and their allies. We believe that many more actors exist who may self-identify as having change-making agency when reading this report.

In what follows, we outline a series of recommendations stemming from our research. While responsibility for change is suggested, our knowledge is limited as related to the agency and potential of NIC departments and structures. We ask those with power within these systems to engage as creative partners—imagining ways that their agency and power can be applied in finding solutions.

Our hope is for readers to consider these recommendations as an outline to generate and define actions. It is our collective work to "fill in the gaps"; to imagine and create meaningful and sustainable solutions to support NIC students and the wider community by leading pathways to a reduction in deaths, harm, and stigma.

1 Bolster On-Campus Harm Reduction Services

Change Agents: NIC Leadership, Local Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- The need participants expressed for increased harm reduction services on-campus, including Naloxone training and accessibility, drug checking services, and outreach services:

We recommend that NIC Leadership, working with local harm reduction leaders, and in meaningful partnership with Peers and Indigenous representatives, work towards implementing a comprehensive harm reduction service delivery plan on-campus. This plan should include, at minimum, bolstering Naloxone training, drug checking services, and on-campus outreach services, along with measures to increase awareness of these services.

2 Implement College-Wide Harm Reduction Training for Instructors

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- The often-unacknowledged front-line role that instructors play, who are often responding in the moment to students dealing with the toxic drug crisis and other related events:

We recommend that NIC Leadership, working with Deans and Department Chairs, as well as Local Harm Reduction Agencies, Peers, and Indigenous Representatives, create a harm reduction training program for instructors. This program should provide a foundation in harm reduction philosophy, an understanding of the history of the toxic drug crisis (including the legacy of residential schools, among other factors), and its impacts and should equip instructors with the tools to respond to a toxic drug event (i.e. through naloxone training). It should also help instructors recognize when students in their classes might be struggling with these issues, provide instructors with relevant resources to pass on to students, and support instructors to create safe spaces in their classrooms, allowing open discussion of the issues that surround the toxic drug crisis.

3 Address Stigma Through the Creation of Safe Spaces

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- Participants' need for a reduction of stigma on-campus and for the creation of culture change through the development of safe spaces:

We recommend leadership develop a multi-faceted "Safe Spaces Plan." This plan should include: a strategy for increasing dialogue on a College-wide level in relation to the toxic drug crisis and its impacts; a strategy for increasing the Health and Human Services program's number of practicum placements in harm reduction contexts; a strategy for implementing Peer mentorship and teaching opportunities; a strategy for including the Walk With Me model (or a similar engagement model) as an ongoing component of the College's activities; and a review of current and proposed architectural advancements with an aim to reduce hostile architecture on-campus and create welcoming campus spaces.

4 Increase NIC's Connectivity with the Wider Comox Valley Harm Reduction Community.

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- The calls made by participants for increased porousness between NIC's Comox Valley campus environment and wider community-based harm reduction initiatives:

We recommend developing strong relationships and linkages between leaders, faculty, staff, and students within NIC and Comox Valley harm-reduction agencies, including AVI Health and Community Services, the Warming Centre, Community Action Team, Comox Valley Community Health Network's Substance Use Strategy, John Howard Society, Comox Valley Transition Society, etc. These relationships are a foundational building-block to enact recommendations in this report.

5 Develop Educational Opportunities for Peers

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- Participant calls for additional supports for Peers that allow them to access NIC educational opportunities in a safe and supported environment:

We recommend the development of a Peer-focused education program. This program may include opportunities for subsidized education and housing, opportunities for additional wrap-around services alongside educational opportunities (ie: harm reduction, outreach, etc.), and integration of Peer leadership into the program's development and operation. We see this program as paving the way forward in developing a social innovation and leadership role for the College, and as exploring the regenerative and community development potential of community colleges in relation to local crises.

6 Develop an On-Campus Harm Reduction Hub

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- The College's geographic and social position in relation to the Comox Valley Hospital and Aquatic Centre:
- The need expressed for additional on-site harm reduction services;

We recommend the development of an on-campus bricks and mortar Harm Reduction Hub. We see this Hub as serving multiple functions and providing multiple services. The Hub could serve as a focal point for College-wide harm reduction services, including training around Naloxone and drug checking. It could also serve as a hub for outreach services and could engage NIC students from Health and Human Services as employees, and/or in outreach-based practicum placements. The Hub could provide training and resources to instructors, as well as a range of harm reduction services to the on-campus community and beyond. Students living in-residence could access the hub, in addition to people connected to the Hospital who need harm reduction services. The centre could further be used as an office to strategically advance NIC's harm reduction initiatives, thereby furthering social justice and innovation. Leadership for the Hub would include Peers and/or Allies with deep connections to the local harm reduction ecosystem.

7 Evolve Health and Human Service Curriculum, and the Curriculum of Other Departments, to Better-Equip Students to Enter into Workplaces Impacted by the Toxic Drug Crisis.

Change Agents: NIC Leadership, Instructors, Harm Reduction Agencies, Peers, Indigenous Voices.

Acknowledging:

- The dramatic changes that are occurring within the health care field as a result of the toxic drug crisis and the need for new sets of skills and understandings in order to effectively work in this new context:

We recommend a review and evolution of NIC's Health and Human Services curriculum, with the intent to: 1) provide education and context on the evolution of the toxic drug crisis and its impacts; 2) create critical understanding of the principles of harm reduction and the need for equity and inclusion within health care; 3) centre Peer voices and experiences; and 4) foster resilience and changemaking capacity. This move to evolve curriculum should honour Indigenous ways of knowing, being, and learning, and should build on the College's existing efforts to Indigenize its curriculum.

5.1 Summary

These recommendations sketch a series of interconnected pathways forward and together create a "potentials framework" intended by WWM for use by NIC's leadership. They are presented to enable NIC to make progress in reducing harm, deaths, and stigma attached to the toxic drug crisis, and to foster NIC's leading-edge social innovation role. We believe NIC holds the potential to be celebrated and recognized nationally as a campus which integrates principles of harm reduction into its core activities and framework. The institution holds the capacity to play a strong change-making role within the wider Comox Valley community and to radically reinvent the ways in which college-community collaborations related to difficult and complex crises are built.

6 CONCLUSION

In this report, we've explored the key factors that feed the toxic drug poisoning crisis in the Comox Valley (and beyond). We've examined NIC's role (and potential role) in relation to the crisis, through the insights of over 161 research participants. We've looked at how NIC might support people within its community impacted by the toxic drug crisis and how it might support students who are entering a world where the crisis is raging. From insights emerging from our research, we've crafted a series of key recommendations designed to foster change.

If, as many claim, the "opposite of addiction is connection," then a response to the toxic drug crisis necessarily involves a drive to connect people in meaningful ways with one another and with surrounding communities. The recommendations outlined in this report are meant to foster such connectivity—through strategic, systems, and cultural change that underscores the fundamental humanity and worth of Peers; through community change that challenges all of us to rise to a more inclusive understanding of what it means to live and exist together.

In closing, we wish to recognize and thank all who gave their voices, insights, and stories over the course of this project, and who inform our collective work in producing this report. In holding your stories, and in walking with them in step with our community, we hold out hope for a future where dehumanization, stigma, and racism are eradicated, where harm is diminished, community systems are nourished, and where people no longer die from preventable toxic drug poisoning.

REFERENCES

1. British Columbia Coroners Service. Unregulated Drug Deaths in B.C.: Dashboard. British Columbia Coroners Service; 2023. Accessed September 25, 2023. https://app.powerbi.com/view?r=eyJrIjoiYTdiOGJlMmYtZTBm-MC00N2FlLWI2YmYtMDIzOTY5NzkwODViIiwidCI6IjZmZGI1MjAwLTNkMGQtNGE4YS1iMDM2LWQzNjg1ZT-M1OWFkYyJ9
2. Shields, Carolyn M., Gélinas-Proulx, Andréanne. Leading for Equity and Social Justice: Systemic Transformation in Canadian Education. University of Toronto Press; 2022.
3. Anderson, Kelli. What is Change Leadership? Harvard Business School Online. Published August 22, 2022. https://online.hbs.edu/blog/post/what-is-change-leadership
4. Henry B, Miller H, Langford B, Bonfonti A, Callander B. Stopping the Harm: Decriminalization of People Who Use Drugs in BC. Provincial Health Officer's Special Report. British Columbia, Office of the Provincial Health Officer; 2019. Accessed August 3, 2023. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf
5. Government of Canada. Opioid- and Stimulant-Related Harms in Canada (June 2023).; 2023. Accessed August 3, 2023. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants
6. British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC: January 1, 2012 – December 31, 2022. British Columbia Coroners Service; 2023. Accessed August 3, 2023. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf
7. Kulkarni, A. 2022 was the deadliest year of the COVID-19 pandemic in B.C. What's next? CBC News. https://www.cbc.ca/news/canada/british-columbia/2022-covid-year-in-review-1.6699063. Published December 29, 2022. Accessed August 3, 2023.
8. CBC News. B.C.'s overdose death toll for the year passes 1,500 after 153 killed in November, coroner reports. CBC News. https://www.cbc.ca/news/canada/british-columbia/bc-overdose-numbers-november-2020-1.5850256. Published December 21, 2020. Accessed August 3, 2023.
9. Woo, A. Opioid-related deaths in Canada nearly doubled during COVID-19 pandemic. The Globe and Mail. https://www.theglobeandmail.com/canada/british-columbia/article-opioid-deaths-canada-pandemic/. Published September 28, 2022.
10. British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC: January 1, 2010 - November 30, 2020. British Columbia Coroners Service; 2020. Accessed August 3, 2023. https://web.archive.org/web/20210206043623/https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug-update.pdf
11. British Columbia Coroners Service. Fentanyl-Detected Illicit Toxicity Deaths: January 1, 2012 to November 30, 2020. British Columbia Coroners Service; 2020. Accessed August 3, 2023. https://www2.gov.bc.ca/as-

sets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/fentanyl-detected-overdose.pdf

12. British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC: January 1, 2011 to January 31, 2021. British Columbia Coroners Service; 2021. Accessed August 3, 2023. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf
13. First Nations Health Authority. Toxic Drug Crisis Events and Deaths and FNHA's Response: Community Situation Report, January 2023. First Nations Health Authority; 2023. Accessed August 3, 2023. https://www.fnha.ca/Documents/FNHA-Toxic-Drug-Poisonings-Community-Situation-Report-January-2023.pdf
14. First Nations Health Authority. First Nations in BC and the Overdose Crisis: Covid-19 Pandemic Sparks Surge in Overdose Deaths. First Nations Health Authority; 2020. Accessed August 3, 2023. https://www.fnha.ca/Documents/FNHA-First-Nations-in-BC-and-the-Overdose-Crisis-Infographic.pdf
15. British Columbia Coroners Service. Illicit Drug Overdose Deaths in BC: Findings of Coroners' Investigations. British Columbia Coroners Service; 2018. Accessed August 3, 2023. https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicitdrugoverdosedeathsinbc-findingsofcoronersinvestigations-final.pdf
16. Canadian Institute for Health Information. Smaller Communities Feeling Impact of Opioid Crisis in Canada. Canadian Institute for Health Information; 2018. Accessed August 3, 2023. https://www.cihi.ca/en/smaller-communities-feeling-impact-of-opioid-crisis-in-canada
17. Fitzgerald T, Hasselback P, Island Health. Data Snapshot - Context: The overdose crisis in small and medium sized BC communities. In: Rural and Indigenous Overdose Action Exchange. ; 2019:8-10. Accessed August 3, 2023. https://www2.gov.bc.ca/assets/gov/overdose-awareness/rural-indigenous-overdose-action-exchange.pdf
18. Stewart B. Overdoses spike in small town B.C. as communities struggle for resources to tackle worsening opioid crisis. CBC News. https://www.cbc.ca/news/canada/british-columbia/overdose-crisis-sechelt-1.5907333. Published 2021. Accessed August 3, 2023.
19. BC Emergency Health Services. Overdose Response in BC Communities. Provincial Health Services Authority; 2021. Accessed August 3, 2023. http://www.bcehs.ca/health-info-site/Documents/Overdose%20Response%20in%20BC%20Communities%20PDF.pdf
20. Government of British Columbia. Health Boundaries. Government of British Columbia. Published 2023. Accessed August 3, 2023. https://www2.gov.bc.ca/gov/content/data/geographic-data-services/land-use/administrative-boundaries/health-boundaries
21. Ubelacker, Sheryl. Canada's opioid crisis is burdening the health care system, report warns. Global News. https://globalnews.ca/news/3743705/canadas-opioid-crisis-is-burdening-the-health-care-system-report-warns/. Published September 24, 2017.
22. Patel, Sapan, Sheikh, Asad, Nazir, Natasha, Monro, Shannon, Anwar, Ammaar. The Opioid Crisis: How to Lessen the Burden on Emergency Departments by At-risk Populations. Cureus. 2020;12(11):e11498. doi:10.7759/cureus.11498
23. Legislative Assembly of British Columbia, Select Standing Committee on Health. Closing Gaps, Reducing Barriers: Expanding the Response to the Toxic Drug and Overdose Crisis.; 2022. https://www.leg.bc.ca/content/CommitteeDocuments/42nd-parliament/3rd-session/health/report/SSC-Health-Report_42-3_2022-11-01_Final.pdf
24. Karsten, Sharon, Mark, Andrew, Hauschildt, Christopher, Thomas, Zarya Chelsea. Pathways Forward - Island Health & the Toxic Drug Poisoning Crisis. Walk With Me; 2022. Accessed August 22, 2023. https://static1.squarespace.com/static/6312d888d5cd4057e5cdfc07/t/63d032ae7e238532077c0fb1/1674588856663/WWM+REPORT+ISLAND+HEALTH.pdf

25. Siebarth, Tara. Universities come to grips with Canada's opioid overdose crisis. University Affairs. Published March 8, 2017. https://www.universityaffairs.ca/news/news-article/universities-come-grips-canadas-opioid-overdose-crisis/
26. Johal, Rumneek. International Students Are Dying From Overdoses at an Alarming Rate. But BC's Government Isn't Tracking the Problem. pressprogress.org. https://pressprogress.ca/international-students-overdoses-british-columbia-20230116/. Published Jaunary 2023.
27. Garofalo, Sarah. The opioid crisis in Canadian university students. Excalibur. Published November 4, 2021. https://www.excal.on.ca/news/2021/11/04/the-opioid-crisis-in-canadian-university-students/
28. Dyck, Tim, Reist, Dan. Harm Reduction: A Guide For Campus Communities. University of Victoria; 2021. Accessed August 22, 2023. https://www.uvic.ca/research/centres/cisur/assets/docs/hmhc-harm-reduction-campus-guide-final.pdf
29. University of British Columbia. Substance use health and harm reduction. University of British Columbia - Student Services. Published 2023. Accessed August 22, 2023. https://students.ubc.ca/health/health-topics/substance-use-health-harm-reduction
30. Vancouver Community College. What students need to know about toxic drugs in B.C. Vancouver Community College. Published September 14, 2021. Accessed August 22, 2023. https://www.vcc.ca/about/college-information/news/article/what-students-need-to-know-about-toxic-drugs-in-bc.html
31. Davis K. Everything you need to know about fentanyl. Medical News Today. https://www.medicalnewstoday.com/articles/308156. Published January 22, 2019. Accessed August 3, 2023.
32. Bronwell C. For fentanyl importers, Canada Post is the shipping method of choice. Maclean's. https://www.macleans.ca/news/canada/fentanyl-mail/. Published March 7, 2019. Accessed August 3, 2023.
33. Howlett K, Woo A. A Killer High: Fentanyl's Deadly Path - How the powerful drug gets across Canada's border and into the hands of users. The Globe and Mail. https://www.theglobeandmail.com/news/national/how-fentanyl-is-getting-through-canadas-border/article29547443/. Published 2016. Accessed August 3, 2023.
34. Howlett K, Giovannetti J, Vanderklippe N, Perreaux L. A Killer High: How Canada got addicted to fentanyl. Globe and Mail. https://www.theglobeandmail.com/news/investigations/a-killer-high-how-canada-got-addicted-tofentanyl/article29570025/. Published April 8, 2016. Accessed August 3, 2023.
35. Tamminga M. Another drug alert has been issued for Penticton. Penticton Western News. https://www.pentictonwesternnews.com/news/another-drug-alert-has-been-issued-for-penticton/. Published January 5, 2021. Accessed August 3, 2023.
36. Smith J. Two drug alerts issued in North Okanagan. Kelowna Capital News. https://www.kelownacapnews.com/news/two-drug-alerts-issued-in-north-okanagan/. Published January 8, 2021. Accessed August 3, 2023.
37. Reynolds R. Coronavirus pandemic aggravates opioid crisis amid rise in overdoses, decline in services. Global News. https://globalnews.ca/news/7463803/coronavirus-worsens-opioid-crisis/. Published November 15, 2020. Accessed August 3, 2023.
38. Government of British Columbia. Lethal Drugs are Circulating. Government of British Columbia. Published 2023. Accessed August 3, 2023. https://www2.gov.bc.ca/gov/content/overdose/lethal-drugs-are-circulating
39. St. Denis J. Why B.C.'s illicit drugs are increasingly deadly. Prince George Citizen. https://www.princegeorgecitizen.com/news/local-news/why-b-c-s-illicit-drugs-are-increasingly-deadly-1.24187413. Published August 16, 2020. Accessed August 3, 2023.
40. Uguen-Csenge E. B.C. releases plan to provide safe supply of drugs during COVID-19 pandemic. CBC News. https://www.cbc.ca/news/canada/british-columbia/safe-supply-drug-plan-covid-1.5511973. Published March 26, 2020. Accessed August 3, 2023.

41. Howell M. “Safe supply” of drugs good news in Vancouver, but is it only here for the pandemic? Vancouver is Awesome. https://www.vancouverisawesome.com/courier-archive/news/safe-supply-of-drugs-good-news-in-vancouver-but-is-it-only-here-for-the-pandemic-3120087. Published March 27, 2020. Accessed August 3, 2023.
42. Whyton M. ‘Life-saving and Life-changing’: BC’s Safe Supply Program Gets Major Expansion. The Tyee. https://thetyee.ca/News/2020/09/16/Safe-Supply-Expansion/. Published September 16, 2020. Accessed August 3, 2023.
43. Whyton M. BC’s New Addictions Minister Promises Action on Safe Supply, Overdose Prevention. The Tyee. https://thetyee.ca/News/2020/12/10/BC-New-Addictions-Minister/. Published December 10, 2020. Accessed August 3, 2023.
44. Whyton M. Experts Reject BC’s Safe Supply Claims. The Tyee. https://thetyee.ca/News/2022/03/03/Experts-Reject-BC-Safe-Supply-Claims/#:~:text=Safe%20supply%20is%20a%20method,people%20in%20B.C.%20last%20year. Published March 3, 2022. Accessed August 3, 2023.
45. Owen, B. B.C. officials push back against safe supply critics and their ‘polarizing rhetoric.’ Vancouver Island Free Daily. https://www.vancouverislandfreedaily.com/news/b-c-officials-push-back-against-safe-supply-critics-and-their-polarizing-rhetoric/. Published June 6, 2023. Accessed August 3, 2023.
46. Eibl JK, Morin K, Leinonen E, Marsh DC. The State of Opioid Agonist Therapy in Canada 20 Years after Federal Oversight. Can J Psychiatry. 2017;62(7):444-450. doi:10.1177/0706743717711167
47. Pearce LA, Min JE, Piske M, et al. Opioid agonist treatment and risk of mortality during opioid overdose public health emergency: population based retrospective cohort study. BMJ. 2020;368:m772. doi:10.1136/bmj.m772
48. Beamish L, Sagorin Z, Stanley C, et al. Implementation of a regional quality improvement collaborative to improve care of people living with opioid use disorder in a Canadian setting. BMC Health Serv Res. 2019;19:663. doi:10.1186/s12913-019-4472-8
49. Socías ME, Wood E, Kerr T, et al. Trends in engagement in the cascade of care for opioid use disorder, Vancouver, Canada, 2006–2016. Drug and Alcohol Dependence. 2018;189:90-95. doi:10.1016/j.drugalcdep.2018.04.026
50. Beamish L, Sagorin Z, Stanley C, et al. Implementation of a regional quality improvement collaborative to improve care of people living with opioid use disorder in a Canadian setting. BMC Health Serv Res. 2019;19:663. doi:10.1186/s12913-019-4472-8
51. Health Canada. Best Practices: Methadone Maintenance Treatment. Health Canada; 2002. Accessed August 3, 2023. https://www.deslibris.ca/ID/250764
52. The Canadian Medical Protective Association. Opioids: We Can Do Better. The Canadian Medical Protective Association; 2016. Accessed August 3, 2023. https://www.cmpa-acpm.ca/static-assets/pdf/about/annual-meeting/com_16_opioid_We_can_do_better-e.pdf
53. Busse JW, Craigie S, Juurlink DN, et al. Guideline for opioid therapy and chronic noncancer pain. CMAJ. 2017;189(18):E659-E666. doi:10.1503/cmaj.170363
54. National Opioid Use Guideline Group. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. National Opioid Use Guideline Group; 2010. Accessed August 3, 2023. https://web.archive.org/web/20210414160005/https://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_a_v4_5.pdf
55. Jones W, Vojtila L, Kurdyak P, Fischer B. Prescription opioid dispensing in Canada: an update on recent developments to 2018. J of Pharm Policy and Pract. 2020;13:68. doi:10.1186/s40545-020-00271-x
56. Canadian Institute for Health Information. Opioid Prescribing in Canada: How Are Practices Changing?

Canadian Institute for Health Information; 2019. Accessed August 3, 2023. https://www.cihi.ca/sites/default/files/document/opioid-prescribing-canada-trends-en-web.pdf

57. Canadian Centre on Substance Use and Addiction. Prescription Opioids. Canadian Centre on Substance Use and Addiction; 2020. Accessed August 3, 2023. https://www.ccsa.ca/sites/default/files/2020-07/CCSA-Canadian-Drug-Summary-Prescription-Opioids-2020-en.pdf
58. Cheng T, DeBeck K. Between a rock and a hard place: Prescription opioid restrictions in the time of fentanyl and other street drug adulterants. Canadian Journal of Public Health. 2017;108(3):e325-e327. doi:10.17269/CJPH.108.6075
59. Riley D. Drugs and Drug Policy in Canada: A Brief Review and Commentary. Canadian Foundation for Drug Policy & International Harm Reduction Association. Prepared for the Senate of Canada.; 1998. Accessed August 3, 2023. http://www.cfdp.ca/sen8ex1.htm
60. Jensen EL, Gerber J. State Efforts to Construct a Social Problem: The 1986 War on Drugs in Canada. The Canadian Journal of Sociology / Cahiers canadiens de sociologie. 1993;18(4):453-462.
61. Salter L, Green M. Royal Commission on the Non-medical Use of Drugs. In: The Canadian Encyclopedia; 2013. https://www.thecanadianencyclopedia.ca/en/article/royal-commission-on-the-non-medical-use-of-drugs
62. Toronto Public Health. Quick Facts: Canada's Drug Laws and Strategies. Toronto Public Health; 2018. Accessed August 3, 2023. https://www.toronto.ca/wp-content/uploads/2018/05/970c-Canadas-Drug-Laws-Strategies.pdf
63. Government of Canada. The New Canadian Drugs and Substances Strategy: Backgrounder. Published 2016. Accessed August 3, 2023. https://www.canada.ca/en/health-canada/news/2016/12/new-canadian-drugs-substances-strategy.html
64. Geddes J. Harper's anti-drug strategy gets a little less compassionate. Maclean's. https://www.macleans.ca/news/canada/drug-money/. Published July 25, 2012. Accessed August 3, 2023.
65. Boyd S. Drug Arrests in Canada, 2017: Addendum. Vancouver Area Network of Drug Users; 2018. Accessed August 3, 2023. https://drugpolicy.ca/wp-content/uploads/2018/09/Addendum.pdf
66. Gordon T. Neoliberalism, Racism, and the War on Drugs in Canada. Social Justice. 2006;33(1):59-78.
67. Solomon R. The Noble Pursuit of Evil: Arrest, Search, and Seizure in Canadian Drug Law. In: Illicit Drugs in Canada: A Risky Business. Nelson; 1988:263-290.
68. Stockwell T, Dorocicz J, Young M, et al. Canadian Substance Use Costs and Harms, 2015-2017. Canadian Centre on Substance Use and Addiction; 2020. Accessed August 3, 2023. https://csuch.ca/publications/CSUCH-Canadian-Substance-Use-Costs-Harms-Report-2020-en.pdf
69. Deachman B. Substance use in Canada costs $46B, 75,000 lives annually. Ottawa Citizen. https://ottawacitizen.com/news/local-news/substance-use-in-canada-costs-46b-75000-lives-annually. Published July 7, 2020. Accessed August 3, 2023.
70. Toronto Public Health. Discussion Paper: A Public Health Approach to Drugs. Toronto Public Health; 2018. Accessed August 3, 2023. https://www.toronto.ca/wp-content/uploads/2018/05/9105-A-Public-Health-Approach-to-Drugs-Discussion-Paper.pdf
71. Department of Justice Canada. The Impact of Mandatory Minimum Penalties on Indigenous, Black and Other Visible Minorities.; 2017. Accessed August 3, 2023. https://www.justice.gc.ca/eng/rp-pr/jr/jf-pf/2017/oct02.html
72. Fumano, D. New figures reveal the racial disparity in Vancouver drug charges. The Vancouver Sun. https://vancouversun.com/news/local-news/racial-disparity-in-vancouver-drug-charges-data-shows. Published August 7, 2020. Accessed August 3, 2023.

73. Office of the Correctional Investigator, Canada. A Case Study of Diversity in Corrections: The Black Inmate Experience in Federal Penitentiaries: Final Report. Office of the Correctional Investigator, Canada; 2014. Accessed August 3, 2023. https://web.archive.org/web/20230507085710/https://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20131126-eng.aspx
74. Harati, D. Inside Insite: How a Localized Social Movement Led the Way for North America's First Legal Supervised Injection Site. Harvard Law School, Irving Oberman Memorial Student Writing Prize: Law and Social Change. Published online 2015. https://dash.harvard.edu/handle/1/16386592
75. Government of Ontario. Overdose Prevention Sites: User Guide for Applicants. Ministry of Health and Long-Term Care; 2018. Accessed August 3, 2023. https://pub-london.escribemeetings.com/filestream.ashx?DocumentId=38863
76. Health Canada. Good Samaritan Drug Overdose Act Becomes Law in Canada. Government of Canada. Published 2018. Accessed August 3, 2023. https://www.canada.ca/en/health-canada/news/2017/05/good_samaritan_drugoverdoseactbecomeslawincanada.html
77. Barron L. Canada Has Just Passed a Landmark Bill Legalizing Recreational Marijuana. Time. Published online 2018. https://time.com/5316777/canada-legalizes-recreational-marijuana/
78. Liberal Party of Canada. An Act to Amend the Criminal Code and the Controlled Drugs and Substances Act: First Reading, February 18, 2021.; 2021. Accessed August 3, 2023. https://parl.ca/DocumentViewer/en/43-2/bill/C-22/first-reading
79. Tam, T, Levine, R. Joint Statement by the Chief Public Health Officer of Canada, Dr. Theresa Tam, and Assistant Secretary for Health Admiral Rachel Levine, MD, on Substance Use and Harms During COVID-19. US Department of Health and Human Services. Published September 27, 2022. Accessed August 3, 2023. https://www.hhs.gov/about/news/2022/09/27/joint-statement-chief-public-health-officer-canada-dr-theresa-tam-assistant-secretary-health-admiral-rachel-levine-md-substance-use-harms-during-covid-19.html
80. Ferreira S. Portugal's radical drugs policy is working. Why hasn't the world copied it? The Guardian. https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it. Published 2017. Accessed August 3, 2023.
81. UNAIDS. Decriminalization works, but too few countries are taking the bold step. UNAIDS. Published March 3, 2020. Accessed August 3, 2023. https://www.unaids.org/en/resources/presscentre/featurestories/2020/march/20200303_drugs
82. Canadian Public Health Association. Decriminalization of Personal Use of Psychoactive Substances. Canadian Public Health Association. Published November 6, 2017. Accessed August 3, 2023. https://www.cpha.ca/decriminalization-personal-use-psychoactive-substances
83. Canadian Association of Chiefs of Police. Findings and Recommendations Report - Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing. Canadian Association of Chiefs of Police; 2020. Accessed August 3, 2023. https://www.cacp.ca/index.html?asst_id=2189
84. Zussman R. B.C. premier formally asks federal government to decriminalize illegal drugs. Global News. https://globalnews.ca/news/7199147/horgan-decriminalize-illegal-drugs/. Published 2020. Accessed August 3, 2023.
85. City of Vancouver. Decriminalizing Poverty and Supporting Community Led Safety Initiatives: Process Update and Recommendation. City of Vancouver; 2021. https://council.vancouver.ca/20210428/documents/cfsc1.pdf
86. Nassar HM. Vancouver, Health Canada, to formally discuss decriminalization, mayor says. News 1130. https://www.citynews1130.com/2021/01/27/vancouver-health-canada-discuss-drug-decriminalization/. Published January 27, 2021. Accessed August 3, 2023.

87. British Columbia MH and A. B.C. receives exemption to decriminalize possession of some illegal drugs for personal use. BC Government News. Published May 31, 2022. Accessed August 3, 2023. https://news.gov.bc.ca/releases/2022MMHA0029-000850
88. Canadian Drug Policy Coalition. Legal Regulation. Canadian Drug Policy Coalition. Published 2022. Accessed August 3, 2023. https://drugpolicy.ca/our-work/issues/legal-regulation/
89. Goldstein D. This cop says it's time to legalize all drugs. Pacific Standard. https://psmag.com/news/cop-says-time-legalize-drugs-80381. Published May 3, 2017. Accessed August 3, 2023.
90. Ritter A. Decriminalisation or legalisation: injecting evidence in the drug law reform debate. National Drug & Alcohol Research Centre: UNSW Sydney. Accessed August 3, 2023. https://ndarc.med.unsw.edu.au/blog/decriminalisation-or-legalisation-injecting-evidence-drug-law-reform-debate
91. Canadian Drug Policy Coalition. Evidence Around Harm Reduction and Public Health-Based Drug Policies. Canadian Drug Policy Coalition; 2023. Accessed August 3, 2023. https://drugpolicy.ca/resources/evidence/
92. McElroy, J. B.C. municipalities push for clarity around drug decriminalization. CBC News. https://www.cbc.ca/news/canada/british-columbia/bc-decriminilization-bylaws-cities-1.6831544. Published May 3, 2023. Accessed August 3, 2023.
93. Yanor, F. Municipalities want rules on drug use for safety of all citizens. Northern Beat. https://northern-beat.ca/news/municipalities-drug-ban-for-everyones-safety/. Published May 1, 2023. Accessed August 3, 2023.
94. Taylor, A. Campbell River formally passes controversial public drug consumption ban. Campbell River Mirror. https://www.campbellrivermirror.com/news/campbell-river-formally-passes-controversial-public-drug-consumption-ban/. Published July 31, 2023. Accessed August 3, 2023.
95. Al-Tawil J. Housing Statistics in Canada: Homeownership, Income, and Residential Property Values. Statistics Canada; 2019. Accessed August 3, 2023. https://www150.statcan.gc.ca/n1/pub/46-28-0001/2019001/article/00002-eng.htm
96. Rozworski M. The roots of our housing crisis: Austerity, debt and extreme speculation. Policy Note. Published 2019. Accessed August 3, 2023. https://www.policynote.ca/the-roots-of-our-housing-crisis-austerity-debt-and-extreme-speculation/
97. Vancouver Island Real Estate Board. Monthly Statistics Package - May 2023. VIREB; 2023. Accessed August 3, 2023. http://www.vireb.com/assets/uploads/05may_23_vireb_stats_package_64852.pdf
98. Henley J. "It's a miracle" Helsinki's radical solution to homelessness. The Guardian. https://www.theguardian.com/cities/2019/jun/03/its-a-miracle-helsinkis-radical-solution-to-homelessness. Published 2019. Accessed August 3, 2023.
99. Bank of Canada. Bank of Canada Currency Converter. Published September 22, 2023. Accessed September 22, 2023. https://www.bankofcanada.ca/rates/exchange/currency-converter/
100. Medicine Hat Community Housing Society. Plan to End Homelessness. Medicine Hat Community Housing Society. Published 2022. Accessed August 2, 2023. https://mhchs.ca/homelessness-initiatives/plan-to-end-homelessness/
101. Maddess, R. Mental Health Care in Rural British Columbia. BC Medical Journal. 2006;48(4):172-173.
102. Woo A. Mental health and addiction services lacking in B.C., report says. The Globe and Mail. https://www.theglobeandmail.com/news/british-columbia/mentally-ill-adults-need-more-access-to-services-bc-auditor-general/article30063324/. Published May 17, 2016. Accessed August 3, 2023.
103. Lupick T. B.C. coroner's report reveals a troubling divide between urban and rural mental-health challenges. The Georgia Straight. https://www.straight.com/life/1268231/bc-coroners-report-reveals-troubling-divide-between-urban-and-rural-mental-health. Published July 18, 2019. Accessed August 3, 2023.

104. Office of the Provincial Health Officer. Taking the Pulse of the Population: An Update on the Health of British Columbians.; 2019. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/pho-annual-report-2019.pdf
105. Little S. $500M for mental health and opioid crisis, as B.C. budget boosts health spending by $2.6B. Global News. https://globalnews.ca/news/7774208/500m-for-mental-health-and-opioid-crisis-as-b-c-budget-boosts-health-spending-by-2-6b/. Published April 20, 2021. Accessed August 3, 2023.
106. Canadian Mental Health Association. Budget 21: BC government sets important precedent for mental health and substance use funding. Published 2021. Accessed August 3, 2023. https://cmha.bc.ca/news/budget-2021-important-precedent-for-mental-health-and-substance-use-funding-set-by-bc-government/
107. CBC News. More than $1B announced for mental health, addictions support in 2023. CBC News. https://www.cbc.ca/news/canada/british-columbia/more-than-1b-announced-for-mental-health-addictions-support-in-2023-1.6763706. Published February 28, 2023. Accessed August 3, 2023.
108. Alexander B. The Globalisation of Addiction: A Study in Poverty Of The Spirit. Oxford University Press; 2008.
109. Gabor Maté: The Myth of Normal.; 2020. Accessed August 3, 2023. https://www.youtube.com/watch?v=8lKJsqeFlko
110. Creative City Network of Canada. Cultural Mapping Toolkit. Creative City Network of Canada; 2010. Accessed August 3, 2023. https://www.creativecity.ca/product/cultural-mapping-toolkit/
111. Poole P. Cultural Mapping and Indigenous Peoples: A Report for UNESCO. UNESCO; 2003. Accessed August 3, 2023. https://unesdoc.unesco.org/ark:/48223/pf0000159090
112. Harvard University, Center on the Developing Child. ACEs and Toxic Stress: Frequently Asked Questions. Center on the Developing Child. Published n.d. Accessed August 24, 2023. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/
113. Centres for Disease Control and Prevention. Adverse Childhood Experiences (ACEs). Violence Prevention. Published June 29, 2023. Accessed August 24, 2023. https://www.cdc.gov/violenceprevention/aces/index.html