

WALK WITH ME

PATHWAYS FORWARD

ISLAND HEALTH & THE TOXIC DRUG POISONING CRISIS

Report from “Walk With Me: Island Health” Research
Sessions

Comox Valley Hospital, Campbell River Hospital, Oceanside
Health Centre:

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ETHICS STATEMENT

The authors, whose names appear on the title page of this work, have obtained human research ethics approval from Thompson Rivers University's, Island Health's, and Vancouver Island University's Office of Research Ethics for the research described in this report.

LAND ACKNOWLEDGEMENT

We are grateful to the Kómoks peoples, including the Pentlatch, Sathlout, Satsitla, Leeksen on who's unceded territory we live, work and play. We are thankful to the Coast Salish, Nuu-chah-nulth, and Kwak'wala peoples and visitors on Vancouver Island for supporting Walk With Me in our work.

ABSTRACT

Since labelled a provincial public health emergency in 2016, the toxic drug poisoning crisis in BC has claimed over 10,000 lives. Government, health and community service providers alike have struggled to find solutions to the crisis and have developed numerous interventions aimed to reduce deaths, harm and stigma. Despite these efforts, toxic drug deaths have continued to climb, with 2021 recording the most fatalities ever and 2022 already exceeding 2021's January to October count.

“Walk With Me” is a research and community action project developed in small BC communities, beginning in Comox Valley and Campbell River, BC. The project began in 2019 as a partnership between Comox Valley Art Gallery, Thompson Rivers University and AVI Health & Community Services, aiming to develop humanistic and systems-based solutions. In 2021, the project team was invited to work with Island Health to engage staff in Central and North Island facilities in a multi-tiered research initiative. The staff from these facilities join “Story Walks”—a series of guided listening journeys foregrounding local first-hand testimony of the crisis. Following the walks, staff were invited to sit in-circle, and to share insights and respond to the question: “How can Island Health better-serve people at the heart of this crisis?” In collecting and analyzing staff insights, the project aims to illuminate ways forward for Island Health towards progressive institutional change.

DEDICATION

This piece is dedicated to all who shared their stories with courage and to those whose lives have been lost. We remember our much-missed collaborators—friends tragically taken even as we worked together for change. We honour, as well, all whose names have been spoken in memory, whose stories continue to compel us forward in pursuit of transformation.

We honour you, and we think about you often—especially when we walk.

TABLE OF CONTENTS

Ethics Statement	ii
Land Acknowledgement	iii
Abstract	iv
Dedication	v
Table of Contents	vi
Chapter 1. Introduction	1
Chapter 2. Context	3
2.1. Background	3
2.1.1. Where is the Crisis Unfolding and Who is Most Impacted?	4
2.1.2. What Can Be Done?	4
2.2. Island Health Leadership	6
2.3. Summary	7
Chapter 3. Project History & Methods	8
3.1. Why Small Cities?	10
3.2. Why Use Cultural Mapping as a Core Methodology?	11
3.3. How is the Project Structured?	13
3.4. What Are the Project's Objectives?	13
3.5. Limitations	14
3.6. Summary	14
Chapter 4. Findings	15
4.1. HONOURING PEER LEADERSHIP, PEER STORIES AND THE HUMAN DIMENSIONS OF THE CRISIS	16
4.1.1. Peer Voices for Developing Strategies, Situating, Contextualizing, and Humanizing	16
4.1.2. Acknowledging and Combatting Stigma	21
4.1.3. Summary	22
4.2. FILLING GAPS IN THE SYSTEM / PROVIDING FULL-SPECTRUM CARE	23
4.2.1. Strengthen timely detoxification, mental health and social supports	23
4.2.2. Integrate Island Health and Community Services	29
4.2.3. Reduce Caseloads	31
4.2.4. Summary	33
4.3. Unlearning and Relearning, Rebalancing and Innovation	33
4.3.1. Unlearning and Relearning	33
4.3.2. Rebalancing and Innovation	36
4.4. Summary	37

Chapter 5. Recommendations	38
Chapter 6. Conclusions	44
Appendix A: Background	45
A. HISTORY	45
B. LOCATING IMPACT	47
B.1 Who is Most Impacted by this Crisis? (Demographics/ Characteristics)	47
B.2 Where is this Crisis Unfolding? (Rural vs Urban)	49
B.3 How is the Overdose Crisis Unfolding in Vancouver Island Health Authority and in the North Island Service Delivery Area?	50
B.4 How is the Crisis unfolding in the North Vancouver Island?	50
C. WHAT ARE KEY CONTRIBUTING FACTORS?	51
C.1 Increase in Toxic Supply / Provision of Safe Supply	51
C.2 Safe Supply	52
C.3 Opioid Agonist Therapy	53
C.4 Over-Prescription of Opioid-based Pain Medication	54
C.5 Criminalization	55
C.6 Failure to Decriminalize	58
D. UPSTREAM SERVICES - SOCIAL DETERMINANTS OF HEALTH	60
D.1 Housing	60
D.2 Mental Health Services	61
D.3 Education	61
D.4 Hypercapitalism and 'Poverty of the Spirit'	62
D.5 Island Health – Efforts	63
E. SUMMARY	65
References	67

1

INTRODUCTION

“Walk With Me” is a research and community action project developed in response to a toxic drug poisoning crisis that is blindsiding municipal governments, institutions and communities large and small across the country. The crisis is having a heavy impact in BC. Since it was labeled a provincial public health emergency in 2016, illicit drug toxicity deaths have totalled over 10,000. For governments, communities, front-line workers, families and people with lived and living experience, the crisis can feel insurmountable. This project, a research and community action project coordinated through the Comox Valley Art Gallery in partnership with Island Health, Thompson Rivers University, AVI Health and Community Services and an array of community partners, brings together diverse stakeholders to re-frame the crisis through a process of cultural mapping to imagine new ways forward.

As its central research question, Walk With Me asks: **“How can community-based research investigating the toxic drug poisoning crisis help save lives, reduce harm, improve social**

cohesion and create systems change for populations facing the crisis first-hand in small and rural communities?” This project aims to understand how this crisis is playing out uniquely in BC’s small communities and to shine light on the stories of human loss, crisis and resilience emerging through it.

From 2021 to 2022, Walk With Me received ethics approval to work within acute care settings in select Island Health facilities. As part of this work, Island Health staff teams were invited to listen to (and walk with) audio tracks compiled by the Walk With Me team that foregrounded the voices and stories of People with Lived and Living Experience (PWLLE). Staff were then invited to respond to the following research question: **“How can Island Health better-support people at the heart of the toxic drug poisoning crisis?”**

This report emerges from these sessions. It documents and analyzes staff responses to this question and presents a series of ensuing change recommendations.

The report includes the following sections: Introduction (Chapter 1), Context (Chapter 2), Project History and Methods (Chapter 3), Findings (Chapter 4), Recommendations (Chapter 5) and Conclusion (Chapter 6). Together, these chapters shine light on potential pathways forward for Island Health in reducing deaths, stigma and harm through systems change-based innovation.

2 CONTEXT

The following segment provides a broad-strokes overview of the contextual factors influencing the rise of the toxic drug poisoning crisis in Canada and British Columbia. Further detailed analysis of these factors can be found in Appendix A and in Walk With Me's Policy Report for the Comox Valley.²

2.1. Background

In April 2016 the province's Health Officer declared a public health emergency due, in-part, to the high toxicity of fentanyl in the illicit drug supply. The province responded to the crisis through a range of interventions, including: public education, targeted information campaigns, increased access to trauma and mental health counselling, increased access to opioid agonist therapies, distribution of naloxone kits, passage of legislative changes, increase of toxicological testing of drugs, expanding harm reduction services (i.e.: establishing toxic drug death prevention services and expanding supervised consumption sites), development of a ministry focused on mental health and

addictions, etc. Yet in spite of these interventions, the rate of toxic drug-related deaths has continued to rise.¹

The crisis has been fuelled by a "perfect storm" that includes an increase in the toxicity of drugs, over-prescription of opioid-based pain medication, criminalization of drugs, the COVID-19 Pandemic, and the rise in social dissonance factors such as unemployment, housing unaffordability and income disparity. These factors, coupled with ongoing stigma, racism, erosion of Mental Health Services and erosion of education, have created and exacerbated the crisis.

A multitude of harms are experienced by individuals, families, workers, institutions, and social systems in association with toxic drug poisoning deaths. The rising figures suggest immense risk for current illicit drug users and describe an increasingly heavy burden carried by health agencies providing support to those at the heart of the crisis.

2.1.1. Where is the Crisis Unfolding and Who is Most Impacted?

Contrary to public imagination, the crisis is not confined to large urban centres.³ Opioid use and illicit drug toxicity deaths in small cities and towns are growing and in some cases surpassing per-capita growth rates in large urban centres. Between 2016 and May 2022, Island Health recorded 1,579 illicit drug toxicity deaths. Within the Island Health region, in 2021 we saw the highest per-capita (per 100,000 people) rates of illicit drug toxicity deaths in North Vancouver Island (48.5), then Central Vancouver Island (41.1), and finally South Vancouver Island (32.6).¹ Here we see the North and Central Island regions, home to small cities and rural and remote landscapes, as more strongly impacted on a per-capita basis than the more densely populated South Island Region.¹

The demographics most impacted include: men ages 19-59, who comprised 79% of fatal illicit drug toxicity deaths in BC between January and August, 2022 ^{3(pp8,9)} and First Nations communities. In 2020, First Nations people died at 5.4 times the rate of other BC residents,⁴ vs. 3.8 times in 2019.⁵ Additionally, people who are under and unemployed, people in the trades and transportation industries, and people who are grappling with pain and mental health

2.1.2. What Can Be Done?

We know concrete action is possible that will rapidly reduce harm. Dominant calls to action involve pragmatic solutions such as: increasing access to Safe Supply and Opioid Agonist Therapy, decriminalization of illicit substances, increasing access to Mental Health Services, and better-managing the prescription of opioids. Other “upstream” solutions consider social determinants of health, for example: housing, education, and inequity. Taken together, these factors represent a systems approach to reducing harms caused by the crisis.

It is within the near-term power of our governments and health institutions to make rapid progress with respect to Harm Reduction, including access to Safe Supply, Opioid Agonist Therapy (OAT), and Mental Health Services. In 2020 the Province announced it would begin to offer drug users “Safe Supply” from a wider range of health professionals than were previously approved to offer this service. Though BC is often taking the lead in a National response, by declaring an emergency, by advancing programs,⁶ the speed of roll-out and response has in some cases, especially in small cities, highlighted inequity of access.^{7 (pp30)} OAT is a treatment strategy that has been in-place within BC for many years. Prescriptions such as methadone

(Methadose) and buprenorphine (Suboxone)—long-acting opioid agonist drugs—are given to lessen and replace dependency on shorter-acting opioids such as heroin, oxycodone and fentanyl. 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.^{8(pp1)}

Rural and remote communities in BC face serious access barriers and lower quality service delivery with respect to not only OAT, but also Mental Health Services, for which there are severe shortages.^{9(pp210),10} Current provincial budgets and programs suggest that our government is working to address this rural and urban imbalance.^{11(pp9)} The changes cannot come soon enough.

It is also within the near-term power of regulatory bodies to find safer systems for managing prescription opioids and tracking how patients are managing their pain. Medical institutions feed opioid dependency through prescription. Canada ranks “second only to the US in per capita consumption of prescription opioids” as a nation.^{12(pp1)} Progress is being made to control excessive opioid prescription, however, regular opioid users may seek illicit supply from the street if they are denied pharmaceutical supply and are not supported in transitioning from their dependency.¹³ More can be done to address this issue.

It is possible to rapidly decriminalize illicit drug use. Criminalization compounds illicit drug harms. Rooted in overt racist politics, Canada’s drug criminalization experiment officially began with the Opium Act of 1908. Though the LeDain Commission recommended a suite of decriminalization policies in 1973, criminalization efforts only increased until 2016 with the release of the Canadian Drugs and Substances Strategy (See Appendix A). Today, a striking number of top BC officials in health, law enforcement, and political fields advocate for decriminalization. Where governments have actively pursued decriminalization, they have rapidly created enormous savings while reducing crime, illicit drug toxicity deaths and accompanying mass social trauma (See Appendix A).

In addition to the aforementioned near-term evidence-based calls to action, dominant proposed solutions also advocate for changes impacting the social determinants of health, whose outlooks are driving people towards social isolation and precarity. For example, consider housing in the Comox Valley, where the benchmark price of a single-family home was \$354,100 in March, 2016, and \$911,700 in June, 2022—an increase of 160%.¹⁴ In Campbell River, the benchmark price of a single-family home was \$281,800 in March of 2016 and was \$761,800 in

June of 2022, a 170% increase.¹⁴

Housing unaffordability, including rents and ownership, directly contributes to homelessness, poverty and addiction in North Vancouver Island.

We know that addiction and quality of education are correlated.¹⁵ BC invests less than every other province into its elementary and secondary students.¹⁶ The Province has consistently stripped classrooms of the specialists needed to support children who are most in need of extra support, including children who are living with the toxic drug poisoning crisis, other addictions, and poverty in their homes and daily life. “The Failure of British Columbia’s school system to meet the needs of the province’s children is particularly true in small and rural communities who have difficulty accessing specialized resources.”^{17(pp10)}

Finally, addiction can be understood as a response to the absence of connection, belonging and collective aspiration. In this view, many forms of physical and emotional distress are seen as a normal response to our failure as a society to acknowledge the consequences of growing inequity. For a portion of the population, the response to increasing erosion of social fabrics occurs in the form of addiction (including drugs and alcohol, but also shopping, gambling, working, exercising, power, money, etc.). When unchecked, these habits temporarily fill the void left by a society consumed with free-market

logics at the expense of human connection.

With consideration for the above factors, we submit that there is strong evidence and consensus to inform strategy and action that dramatically reduces the harm caused by this crisis. Leadership and action is necessary in order to make this courageous shift.

2.2. Island Health Leadership

Island Health holds a leadership role in confronting the crisis— a reality recognized by numerous staff participants in this project, and applauded by our project team. In recent years, Island Health has spearheaded a number of key programs and initiatives designed to address the crisis. These include (but are not limited to):

- Learning about Opioid Use Disorder, “LOUD in the ED.” This program, a component of which hired Peer staff within the emergency department to support patients with mental health and addiction needs, has made big waves in the Campbell River emergency department. The program recognizes that for 21% of people with Opioid Use Disorder experience, their first point of contact with the medical system is through an emergency

department (ED). The program has developed systems changes within the ED designed to make a difference in the lives of those impacted by the toxic drug poisoning crisis.^{18,19}

- Preparing for, budgeting for, and issuing Requests for Proposals to provide Harm Reduction services like Prescribed Safe Supply, Safe Injection and Inhalation Sites, and Opioid Agonist Therapies.²⁰
- Launching a campaign to support those who use substances, targeting men aged 30-59 who represent the majority of toxic drug deaths.^{21,22}
- Exploring and activating novel partnerships like mobile service vans for youth wellness.²³
- Developing and releasing an Island Health-wide “Harm Reduction—Substance Use” policy that directs required organizational practice and behaviour. This policy outlines significant aspirations and strong evidence-based expectations for baseline care, values and quality of service delivery. Island Health staff and leadership can begin to “test” their decisions and actions against the expectations in this policy to see if they are retrogressive, aligned, or exceptional.²⁴
- Contracting Walk With Me and other community organizations to advance harm reduction training and knowledge sharing within Island

Health staff teams.

Walk With Me honours the quest for innovation and improvement demonstrated by Island Health’s leadership through these (and other) harm reduction-based initiatives. Yet the continuous rise in deaths associated with the crisis begs for more to be done. These numbers ask us to consider additional actions, in some cases bold and radical, that can be taken to uncover solutions to the crisis that are rooted in systems change.

2.3. Summary

A multitude of systemic factors drive individuals towards dangerous substances. We’ve acknowledged numerous factors as implicated in the dramatic increase in toxic drug-related deaths brought about since 2016 when the crisis was labeled a provincial public health emergency and have seen how the crisis has unfolded statistically on Vancouver Island. We’ve considered the development of a slate of counter measures within Canada broadly, in BC., and in Island Health, that have emerged in recent years to combat toxic drug-related deaths. The insights provided by Island Health staff in this report are set against this backdrop, and call for a broader innovation agenda to be adopted by Island Health in order to dramatically reduce the harms and deaths associated with this crisis.

3 PROJECT HISTORY & METHODS



“Walk With Me” began in 2019 in the small city of Courtenay, BC. Our work involved sitting “in circle” with People With Lived and Living Experience (PWLLE) of the crisis, Peers, their family members and front-line workers. Using a cultural mapping research methodology, our circles were hosted by a research team including Elders/Knowledge Keepers, Artists, Peers, Community-Engaged Researchers and Outreach Workers. Within our circles, participants were invited to draw and/or

talk about the ways in which the crisis has impacted their lives and communities, and were provided an honoraria, food, art supplies, and various layers of support including cultural safety and outreach. During the circles, powerful insights into the crisis surfaced, and were recorded, through comprehensive ethics protocols.

In the fall of 2020, Walk With Me began sharing these collected insights in the form of “Story Walks”—guided audio journeys that take participants on a 40 minute walk while they listen to audio recordings of the voices and insights gifted to the project by PWLLE, Peers, their family members and front line workers. Participants travel through local neighbourhoods, under bridges, through parks, etc.—all the while allowing the stories, transmitted via mobile headsets, to “wash over them.” Participants then sit together in-circle, guided by Elders and Researchers, and are invited to reflect on and respond to the stories shared. In the Spring of 2021, we were invited to bring the project into Campbell River. Again, we

collected and recorded primary stories, insights, and recommendations from PWLLE of the crisis and Peers, spoke with family members and front-line workers, and in the Fall of 2021, we began walking with the stories, and sitting in-circle, with the wider community.

In 2021, Walk With Me was invited to take the project into Island Health. We began sharing story walks and circles with groups of front-line staff in Island Health acute care facilities. In the Summer of 2021, we received ethics approval to conduct our work within Island Health not only as knowledge dissemination—conducting primary story walks—but as research, where we



systematically collected the secondary reflections and feedback of Staff who understood that their voices would be carried to leadership. We called this branch of the project “Walk With Me: Island Health.” Our research was centred within approved (acute care) facilities within the North- and Mid-Island, including the Campbell River Hospital, Comox Valley Hospital, and Oceanside Health Centre (Parksville). From June, 2021 to June, 2022, we worked with over 200 staff from these facilities, hosting story walks on the lawns of hospitals and inviting staff to participate in sharing/research circles. Our work was anchored by the research question: **“What can Island Health Do to better-serve those at the heart of the toxic drug poisoning crisis?”**

This report documents the insights emerging through “Walk With Me: Island Health.” It constitutes the first of what we hope will be a series of publications—pieces designed to bolster Island Health’s capacity as a ‘learning institution’ to address this crisis. We see this report as one step in a pathway towards institutional systems-based transformation.

3.1. Why small cities?

Much of our work (including our work within Island Health), is located within small cities—population centres with under 150,000 residents. When

attempting to understand the program’s objectives, history and reach, it is useful to reflect on this context. Despite their differences in history, economic stability, social networks, etc., small cities share a common challenge in addressing the health and social welfare needs of their most vulnerable citizens. Such cities are frequently unable to provide the kinds of social, health and economic supports provided in large urban centres. This lack of support is often felt most by those who are socially and economically marginalized or otherwise require different considerations than the general population. Vulnerable populations are often, within small cities, physically removed from services which tend to be centralized in downtown cores—leading to challenges for service providers to reach people in ways that are nimble and strategic.

Small cities also often lack key services and specializations within a “spectra of care.” When crises arise, for instance as related to pandemics, forest fires, floods or the toxic drug poisoning deaths, the resident vulnerable population becomes further affected, displaced and dispersed, leading to even more profound issues of care. Walk With Me foregrounds stories of the crisis as emerging within small cities. We shine a light, in particular, on the unique ways in which small cities in the Mid and North Vancouver Island struggle with the crisis, and on the

potentials they hold for the creation of endogenously-led change.

3.2. Why Use Cultural Mapping as a core methodology?

Cultural mapping, a community-engaged research methodology, can help small cities, their governments and resident institutions alike make the lives of PWLLE of the crises more visible. Cultural Mapping can chart needed connectivity between PWLLE, Peers, family members and frontline social service providers, while also mapping connection between these groups and government, policy-makers and the broader public. Over the last 30 years, cultural mapping has gained international currency as an instrument of collective knowledge building, communal expression, empowerment and community identity formation. Practitioners of cultural mapping combine verbal story and insight sharing with artistic sharing to foster deeper understanding about lived realities.

Our primary mode of mapping occurs through a draw-talk protocol, wherein PWLLE participants either draw about their lived experience, and/or speak to their experiences in the form of circle-based semi-structured interviews. In “Walk With Me: Island Health,” Island Health staff listened to stories derived from our primary mapping while going

on a story walk, and then engaged with the Walk With Me team in a process of reflection, responding to the question:

“What can Island Health do to better-serve those at the heart of the toxic drug poisoning crisis?”

Island Health staff participated in the following sequence of activities with Walk With Me in preparation to discuss the crisis and better support one another:

- 1** Participants were invited by local site managers to participate in the sessions, in collaboration with the Walk With Me team— using invitations pre-approved by Island Health ethics.
- 2** Participants gathered together with the Walk With Me research team, consisting of an Elder/Knowledge Keeper, Researchers, Peers and Outreach Workers, in groups as large as 16 individuals. Participants signed in and reviewed research ethics protocols and consent forms. With the help of Indigenous leadership, Walk With Me oriented the group to the project, and to the traditional practice of sitting in circle to listen and share. Participants were reminded of the consent process verbally, informed of what they were about to hear, and instructed to not “carry the stories” as their own. Participants were asked to honour the stories by holding them in confidence and were given options for removing themselves from the walk and accessing supports if listening became overwhelming.

3 Participants were then distributed wireless headsets. A 40-minute collection of stories gathered from People With Lived and Living Experience of the crisis in either the Comox Valley or Campbell River was then set to broadcast to participant's headsets so the group could listen to the same stories simultaneously. The Walk With Me team then took the participants on a specific route from the hospitals that resonated with the stories.

***Note: Individuals whose voices were used in the audio track understood and consented to their voice being shared with local political leaders, policy makers, Island Health staff and the general public.**

4 After the walk, Island Health participants gathered back together, and were offered a simple warm dish like soup or chilli. The group sat in circle with the research team, and the protocols for deep and respectful listening were reviewed by our Elder. The group was reminded that their responses were being recorded for research purposes. Moving to the left in circle following Coast Salish tradition, participants were invited by the facilitator to share their reactions to the stories and by the facilitator to share their reactions to the stories and respond to the research question: **"What can Island Health do to better- support people at the heart of the crisis?"**

5 A field recorder followed the circle around as research participants shared their reactions to the stories and prompting question. When there was time and a full circuit was completed, the discussion moved across the circle, always with careful respect. Responses were often novel: some staff offered that they had never reflected on these issues in-depth nor in a group context. Some elected not to speak, and others shared that they had never heard anything like these stories before, even those with a great deal of experience working firsthand with PWLLE.

6 In closing the circle, participants were reminded about resources available for mental health support (Island Health supports, as well as other supports) recognizing that the stories may impact participants in unexpected ways post-event.

7 Later, the responses from research participants were transcribed by the research team and coded using NVivo research software, and from this process, the patterns of response emerged that inform this report and its recommendations.

Our objective in reviewing these methodologies is to highlight the unique environment in which Island Health staff were prepared to listen to the stories and respond to the research question. This method was designed to inspire Island Health staff to express their ideas for making systems change while simultaneously fostering community and understanding. Data-collection sessions were 1.5 hours in duration, located at Island Health facilities. “We often met outside the physical facilities—an act that enabled staff to foreground novel and humanistic, as opposed to pre-determined (through physical association with pre-existing clinical contexts) forms of insight. The insights, recommendations, and thematically organized content in this report are built upon the voices of Island Health staff emerging through this context and the voices of PWLLE who inspired them to speak.

3.3. How is the project structured?

The wider Walk With Me project has been developed by Dr. Will Garrett Petts as Principal Investigator (AVP Research, Thompson Rivers University) and Dr. Sharon Karsten (Research Director, Comox Valley Art Gallery) as Co-Investigator. Thompson Rivers University (TRU) and the Comox Valley Art Gallery (CVAG) host the project. The project involves a research team

including Elder/Knowledge Keeper Barb Whyte, Researchers Dr. Andrew Mark, Zarya Thomas, Artist Nadine Bariteau, AVI Health and Community Services Outreach Workers Galen Rigter and Holly Taylor, and Peers Christopher Hauschildt (Administrative Research Coordinator) and Sophia Katsanikakis (Communications Coordinator). AVI Health and Community Services serves as a key Social Services partner. Funders include: Island Health, Vancouver Foundation, BC Arts Council, Koerner Foundation, SPARC BC, National Science and Engineering Research Council, Canada Council for the Arts, and the Union of BC Municipalities.

3.4. What are the project’s objectives?

Key objectives include:

- 1** To enable new ways of thinking about the toxic drug poisoning crisis as it plays out within Walk With Me’s communities of research and within small BC cities generally—leading to systemic forms of change;
- 2** To explore the lived and felt reality of the crisis alongside statistical/empirical data and in relation to cartographic representations of place—honouring the humanity of those at the heart of the crisis;

- 3** To develop insights surrounding the crisis leading to the design of progressive change and transformation;
- 4** To create innovative arts-based research models pertaining to the crisis that are participatory—produced through multi-level community agency; and
- 5** To refine an arts-based methodology to facilitate brave and open conversations about difficult problems in society in the service of uncovering common ground and humanity.

3.5. Limitations

This report provides a broad-strokes overview of key themes, ideas, and change-suggestions emerging from Island Health staff in response to the central research question. In this early work with Island Health, we wanted to foreground stories and insights—to “take the pulse” of staff participants, and to document their insights in a way that would allow them to be seen and heard in new ways.

Moving forward, we see value in also collecting statistical/quantitative analysis that examines the inner frameworks at-play within Island Health (looking at key markers of support for people at the heart of this crisis). Such analysis will allow a deeper understanding to emerge of participant

insights (ie: collecting data from participants related to age, gender, etc. in order to better situate and position staff insight and knowledge). Such analysis will need to be accomplished through additional conversation and partnership with Island Health.

3.6. Summary

Walk With Me: Island Health is a multi-sectoral community-engaged research project designed to create systems change related to the toxic drug poisoning crisis in small BC. community health institutions. The Walk With Me team invites readers to receive this report with an open mind and open heart and to work together with us to catalyze long-term meaningful change.

4 FINDINGS

“The opposite of addiction is connection”

Our findings centre upon the importance of connection, as embodied in the following questions: **“What does it mean to make connection during the crisis?”** and... **“What can happen at Island Health when an opportunity to connect is missed or lost?”** We located moments of (mis)connection within our findings and identified them as opportunities for real systems change.

Our findings stem from research sessions with over 200 staff participants in Island Health’s Mid- and North- Island acute care facilities. After engaging in a story walk (described in Chapter 3) staff were asked to respond to the central research question: **“How might Island Health better-support people at the heart of this crisis?”** The researchers then asked follow-up questions where

participants elaborated on the themes and concepts shared.

The insights gathered spoke to many of the subjects outlined in Chapter 2, but they also locate and illuminate strategic pathways forward as they relate to Island Health’s day-to-day working environment. Insights have been organized into the following three overarching themes:

- 1 Honouring Peer leadership
- 2 Reducing systems gaps
- 3 Creating a climate for learning and cultural change

4.1. Honouring Peer Leadership, Peer Stories and the Human Dimensions of the Crisis

Island Health staff made a recurring call for Peers and the stories of People with Lived and Living Experience of the toxic drug poisoning crisis (PWLLE) to be meaningfully included in organizational and systems change agendas. In this report, we define “Peers” as PWLLE who are engaged in systems change work. Numerous research participants identified Peer leadership and close listening to the voices of PWLLE as essential in the quest to create relevant strategies and actions, situate and contextualize the crisis and develop cultures of empathy, solidarity and understanding. In the following segment, we’ll unpack each of these thematic bundles, and analyze their implications for developing pathways forward.

4.1.1. Peer Voices for Developing Strategies, Situating, Contextualizing, and Humanizing

To begin, many expressed the need to prioritize Peer engagement in **developing relevant and effective strategies**. A number of participants saw dominant top-down strategic development frameworks for policy creation as failing to produce a robust and grounded approach. These

frameworks were seen to discourage tangible solutions to the complex and inter-connected layers of trauma that are lived and experienced by patients (including layers involving homelessness, mental health, shame and stigmatization, etc.). Traditional forms of organizational development locate knowledge for action within outsider expert assessments and the professional “objective” class; they prioritize a global view from above combined with subjectively “neutral” outside recommendations—a vantage point that can overlook, or underplay, important ground-level knowledge. Given this context, Peer engagement was seen to offer deeply refreshing, authentic, and perceptive counterpoints to standard systems change frameworks that often involve consultants who lack a situated and grounded view. Quoting Island Health staff:

We can theorize about gaps in the system from a systems perspective and come up with all sorts of great ideas; but if we are not—if that isn’t informed by the voices and the lived experience of people who are impacted by those gaps—I think we risk missing the point.

(Lindsay Risk—Manager for Community Health Services in Campbell River)

PWLLE stories, like the ones shared by Walk With Me to Island Health staff, are seen as valuable in their capacity to illuminate tangible experiences to inspire solutions rooted in real-world experience:

When I hear [PWLLE] stories, what stands out to me the most is wanting to provide solutions that they want. Not that we think they need, or that we want to provide... the first step is always acknowledging their story.

(Sheila Petersen—Critical Care Manager)

These stories come from people's hearts. They're stories that help to give you some background of the people that are coming through your doors because you don't get a chance to get that [information] when you're working with your patients in a vulnerable situation, in an emergency situation most of the time.

(Elder Barb Whyte—Walk With Me Team Member)

When brought into processes of strategic visioning and planning, the voices of Peers and PWLLE can, it was posited, enable policy development that not only benefits PWLLE, but that acknowledges broader instances of “stigma and judgments that maybe are not knowingly there” within Island Health systems. Many spoke to the importance of Peer expertise in creating awareness: **“using the knowledge and experience of people who have been impacted by the crisis as educators (zoom 182),”** and in developing effective grounded solutions for combating the nuanced and complex realities of the crisis.

Numerous participants recognized, as well, Peer engagement in the Walk With Me leadership and research team, and the inclusion of the stories of PWLLE in our program delivery, as a powerful means to **situate and contextualize the crisis**—enabling a broader picture to emerge surrounding the nature of the barriers faced by people grappling with the crisis first-hand. Many related to us that the stories we shared revealed perspectives to which they had never had prior access. In the following quote, an Island Health staff member speaks to their realization that full comprehension of problems and solutions is not possible to achieve through outsider armchair speculation—understanding comes through listening to insider voices:



I find that there's a lot of reasons for barriers that show up in very marginalized populations, in people who don't have the voice to speak up more loudly, and advocate. So, I think more storytelling, more heartfelt reflection [is needed] ...

(Deidentified Participant #1 Personal Communication)

By closely and intentionally listening to PWLLE stories, participants came to better-understand the context, “the why,” underlying the often-complex struggles that are at-play in exacerbating an individual’s engagement with the crisis:

When people understand the ‘why’ behind things, they’re more likely to adopt different processes.... ‘Why’ is so important, ‘why’ this person is the way they are.

(Deidentified Participant #2 Personal Communication)

Within this focus on Peer voices, and on “the why,” many participants readily acknowledged the importance of context and history in shaping viable solutions to the crisis. Solutions that work to account for “the why,” must unavoidably and inevitably respond to histories of colonization, systemic racism, and intergenerational trauma—often perpetrated on the ground by a medical system in concert with other government bodies.²⁵ Many perceived the act of listening to “why” stories as an essential first-step in helping to ground new ways forward that acknowledge and work to change these histories:

I think that storytelling is one of the most effective ways of learning and expanding knowledge. I think that as a White settler and someone coming from privilege, it’s kind of the least I can do... to come out and hear stories directly from people with lived experience.

(Deidentified Participant #3 Personal Communication)

Dominant biomedical paradigms of treatment for mental health and addictions do not make adequate space for “the why,” and as a consequence, avoid or underplay the socio-economic and cultural roots of the crisis.

Finally, PWLLE voices were honoured for their capacity to **foreground the humanity of those most-impacted by this crisis.** In particular, staff emphasized that relative to other forms of training and learning, such as online modules, meeting in-person with Peers from the Walk With Me team and listening to the stories of PWLLE fostered deeper human connection and empathy:



I think [meeting in-person] touches us as human beings, and I think that's the impact, and the learning, and the self-reflection; understanding our own privileges, and how we are in the world.

(Deidentified Participant #1 Personal Communication)

By meeting on a face-to-face human level and by taking the time required to listen to and share, Island Health staff felt they had opportunities to cultivate empathy and understanding that stood outside their formal education. They came to understand the complexity in which many of their clients are living in a more rich, memorable, and actionable manner:

The stories really help reaffirm how complicated the lives are of the people that are coming through to seek help, and to just have a bit more of an understanding of just how important those few minutes that you spend with that person are.

(Galen Rigter—Harm Reduction Worker, AVI Health and Community Services)

It follows from these comments that better Peer engagement within Island Health's leadership and a better ear for the voices of PWLLE will help build relevant strategic direction, and solidarity and understanding—both within staff teams, and within Island Health's larger approach to the crisis.

We end this section on a cautionary note. While our findings reveal the importance to staff of Peer leadership within Island Health systems, we challenge readers to appreciate what is required of good and rewarding Peer work for change and inclusion. Walk With Me's community engagement work has, at various points, uncovered instances in which Peer leadership and story-sharing was treated carelessly with lasting negative consequences. Engagement with PWLLE must, it follows, occur in ways that are authentic, relational and reciprocal; in ways that value and honour Peer personhood and the diversity of Peer skills and abilities.

Various "best practice" standards, developed in relation to working with and employing Peers, such as those issued by the Canadian Centre on Substance Use and Addiction,²⁶ can inform relationship building before entering into this work. Additionally, institutions looking to more integrally involve Peers in their strategic planning and change agendas would do well to activate meaningful dialogue with Peer

leaders, allies and community advocates in their communities, as well as with Cultural Leaders, in order to find ways to develop these connections and the appropriate supports "in a good way."

4.1.2. Acknowledging and Combatting Stigma

The need for Peer leadership, knowledge and PWLLE story-sharing is positioned against a backdrop that includes the persistent stigmatization of PWLLE within Island Health. Acknowledging the efforts that have been taken by the institution in recent years to combat stigma as described in Chapter 3, there persists, we have heard from participants, an ongoing culture of stigmatization within the organization. This reality is expressed through the following words:

I still run into other healthcare providers being prejudiced or negative, or expressing really closed minded things; and it's really troubling. It's hard to work with people, or hear these things that are still happening in 2021.

(Deidentified Participant #4 Personal Communication)

A lot of times, my clients are not wanting to reach out for help, especially in hospital settings, which is where they go in crisis, and they're not treated well in the hospitals.

(Deidentified Participant #13 Personal Communication)

In some cases, this stigmatizing culture was seen to exist not only “below the surface” in formal and casual interchanges that occur “behind the scenes,” but also in very tangible ways with patients who are denied service:

We'll have nurses that refuse to go different places because of who they're gonna go see, and it's just—you can't do that, for one, but—it's just ridiculous.

(Deidentified Participant #4 Personal Communication)

For some, this culture of stigmatization was seen as particularly difficult to navigate for those new to Island Health, especially those from out of province or internationally, and/or those with little power or clout within its systems:

“ Especially a younger nurse and somebody who is very afraid of conflict, or recourse... if there's a certain culture on your unit, you're not gonna say anything and be that problem person; you just bury it, and you swallow it, and you feel sick; and you dislike your job more and more.”

(Deidentified Participant #5 Personal Communication)

In an agenda to enact progressive forms of institutional change within Island Health, this shaming and stigmatization of people who use substances requires direct confrontation.

4.1.3. Summary

These above insights evidence a need for Peer leadership and PWLLE voices and stories to drive institutional change. By supporting Peers as leaders, strategic development will improve through inclusion of diverse knowledge. Peers and PWLLE and their stories hold capacity to illuminate histories of oppression that have fuelled the crisis, and to connect Island Health and its staff to the human dimensions at-play in the lives of those living the crisis. PWLLE voices, when successfully activated and fully supported for

inclusion, will help produce systems-change frameworks of compassion and empathy that will reduce stigmatization and develop stronger systems of care. The slogan, “Nothing about us without us,” effectively encapsulates the sentiment of Peer and PWLLE inclusivity. It is an old slogan, and a guiding call to action for policy creation. It asks policy makers to include those impacted by new policy in the root development and ownership of that policy. This wisdom is derived from evidence and long experience that inclusive and grounded policy creation produces better research and better policy outcomes. “Nothing about us without us” captures an ethical, inclusive, and methodological research approach to community and evidence-based policy creation. We ask how Island Health might more fully embody and activate this position within its institutional change work related to the toxic drug poisoning crisis.

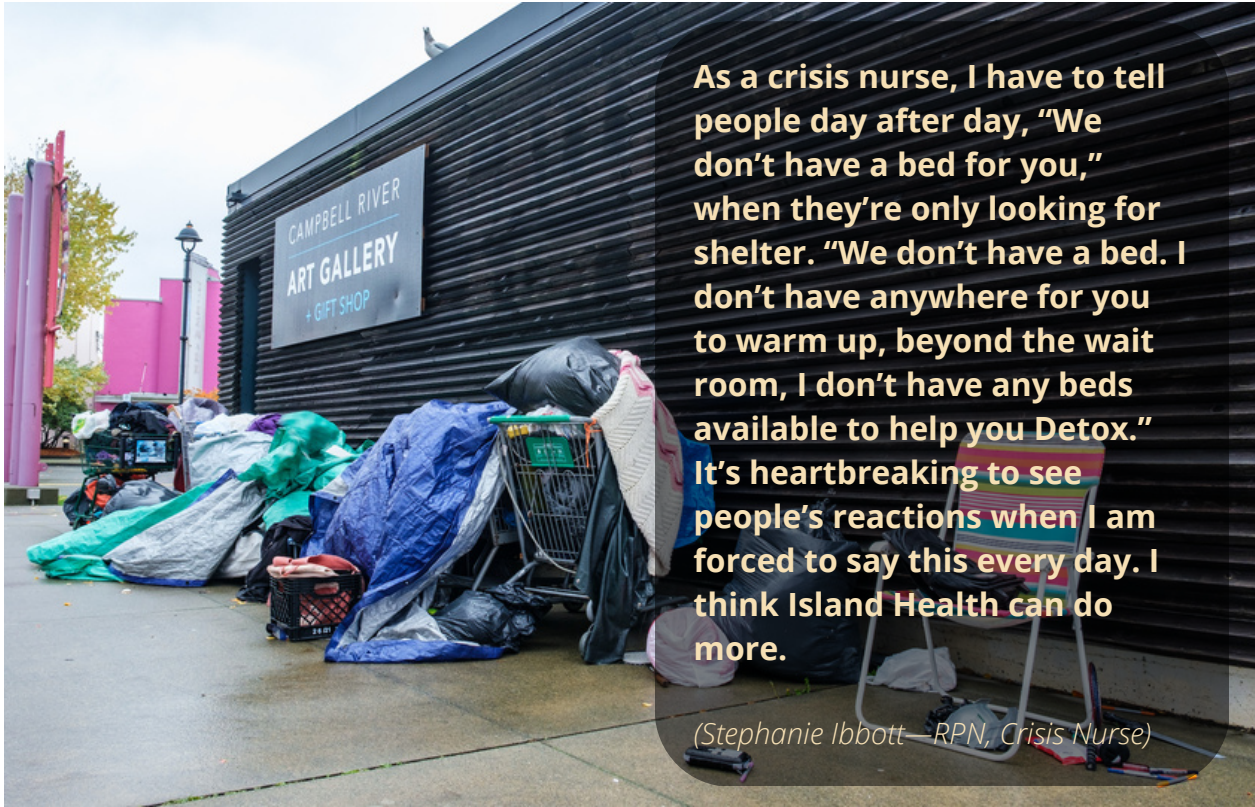
4.2. Filling Gaps in the System/Providing Full-Spectrum Care

In addition to the call from Island Health staff to better-incorporate Peer and PWLLE knowledge into the Island Health system, a second, related call has emerged: to fill gaps in the continuum of care that allows clients and patients to be “dropped”... to fall into gaps within and between services. Staff identified institutional silos and barriers at-play within Island Health. A number of staff

articulated these as detrimental to a holistic and full-spectrum approach to healing and wellness. A call is made here to both strengthen particular services crucial to the wellness of PWLLE (especially services related to detox, mental health and social services) and to better-coordinate services within a wider care ecology. In the following sub-sections, we’ll review staff insights on both fronts.

4.2.1 Strengthen timely detoxification, mental health and social work supports

Staff consistently spoke to the need for strengthened detoxification, mental health and social services supports in Island Health across research sessions. Many spoke to their distress at having to regularly turn clients and patients away due to a lack of detox (and related) resources/supports. Many were particularly distressed by their inability to directly respond to a client with the support they needed “in the moment” of their need, in a timely manner—to offer a bed, a place to warm up, a meal, a place to be while responses were set in motion. An Island Health staff member observes:



As a crisis nurse, I have to tell people day after day, “We don’t have a bed for you,” when they’re only looking for shelter. “We don’t have a bed. I don’t have anywhere for you to warm up, beyond the wait room, I don’t have any beds available to help you Detox.” It’s heartbreaking to see people’s reactions when I am forced to say this every day. I think Island Health can do more.

(Stephanie Ibbott—RPN, Crisis Nurse)

Similarly, this Island Health staff member speaks to the system’s inability to meet even the most basic of human needs—including detox and recovery, but also needs essential survival:

“**Having more supports available: Last week, there was that downpour of rain, and someone was begging for a bed, and he was soaking wet. If we had something to offer him, like soup; we can at least give people some time to warm up and maybe some better clothing. Obviously we can use better supports in the**

community, more housing, and more shelter beds as well as more detox and supportive recovery beds. We just need more.”

(Stephanie Ibbott—RPN, Crisis Nurse)

We noted that comments related to detox were often linked to comments related to basic human needs (food, shelter, clothing). Many acknowledged their ill-preparedness in supporting the spectrum of client needs at the moment in which detox is requested. There is a strong call for Island Health systems to develop ways to meet a much wider spectrum of patient needs

—especially for people entering into acute care who are unhoused, seeking detox, and needing basic levels of survival-based care. In these interventions, time is of the essence:



From my perspective as an outreach worker, a lot of what I do is help really marginalized people navigate the healthcare system, and time and time what I'm told is that [for] people who are seeking medical treatment, it's really complicated for them to show up for their appointments on time. To have transportation to these appointments, and then if and when [they] finally happen, those interactions [however] brief they might be, and [with a] full understanding of how busy everyone is in the healthcare system; the way that [marginalized people] are treated in those moments is so incredibly important. It may be a five-minute slice of your day as a healthcare worker, but for that person it may have been a year between their last check-up or appointment.



*(Galen Rigter—Harm Reduction Worker,
AVI Health and Community Services)*

The system should be able to respond appropriately in the fleeting moments help is actively sought, or these patients will be lost. Basic needs like transportation and adequate food and shelter become barriers to making full use of time-limited moments for positive, supportive, and productive connection with Island Health for people

who are struggling with substance use disorder and other mental illnesses. While moments of contact with clients can seem a relatively brief or small encounter for Island Health, such moments often, in fact, represent the culmination of massive concerted efforts to overcome numerous challenges to get help.

In addition to the request for Island Health to better-meet clients' immediate physical and basic survival needs, staff expressed a desire for support to better-meet clients' mental health, social services and community connectivity needs. While the majority of the staff engaged in the research for this report are positioned within acute care frameworks, these same staff are asking for improved integration of these departments and health paradigms:

They're doing a disservice I think to the public, and to our patients, by asking us to only focus on physical issues; when there's often the mental health/addictions piece [that] is their biggest barrier to succeeding out there.

(Deidentified Participant #6 Personal Communication)

Many participants expressed the view that greater integration of Island Health

departments, and of Island Health services with community services, is needed in part because they feel the supports currently provided within acute care settings are inadequate. In the following quotes, staff members speak from a number of vantage points to the need to bolster and integrate the above supports, and to better-connect Mental Health Services and services, in particular, within Island Health acute care settings:

There's not enough mental health support. And we see it in our youth; we see it in our adults. We can't connect them to services; we can't get them the supports they need.

(Tanis Harrison—Licensed Practical Nurse)

“ We don't even really know the other services, and I know there's one occupational therapist that works in mental health. We've never met them, we don't know how to refer them when it's appropriate, and I just feel like we can do more in that area. ”

(Deidentified Participant #6 Personal Communication)

There's this huge gap, and people—a lot of the nurses I find just don't know how to access the services.

*(Deidentified Participant #7
Personal Communication)*

I'd love to see Mental Health Services increase in a huge way to support people much earlier on in their struggles; as opposed to waiting until we're so far entrenched in our homelessness or addiction that it's hard to get out.

(Tanis Harrison—Licensed Practical Nurse)

“

We need more; we need a lot more psych beds. There's no psych North of Comox, there's no youth psych North of Victoria. There's just not enough resources, and the numbers—the amount of people affected by everything is showing that we clearly need more beds as well as more education I think.

”

(Deidentified Participant #4 Personal Communication)

Acute care gets all the attention. [Acute care] gets to talk about capacity in a different way than community and other community-based programs.

(Deidentified Participant #9 Personal Communication)

“

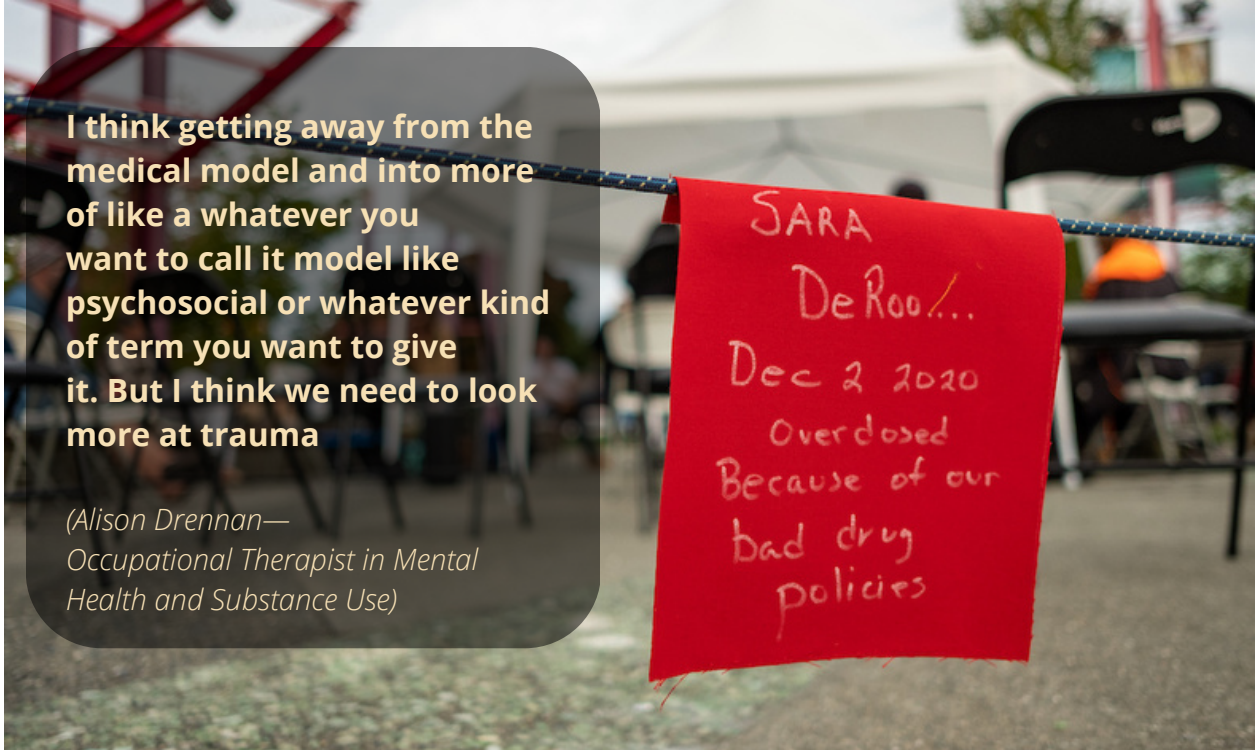
We need way more social workers. There are what, I don't know, 50 nurses in our office, and two social workers. We get referred in way too late to the game. You try to talk about the social determinants of health and access to healthcare is only one of them. But social workers kind of address all of them. Nurses do too; don't get me wrong... super skilled nurses that I work with are all great nurses. But we don't have enough social workers in there.

”

(Deidentified Participant #4 Personal Communication)

I think getting away from the medical model and into more of like a whatever you want to call it model like psychosocial or whatever kind of term you want to give it. But I think we need to look more at trauma

*(Alison Drennan—
Occupational Therapist in Mental
Health and Substance Use)*



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These calls for stronger mental health and social services supports within acute care—for youth, adults, for people in early intervention—reveal significant systems cracks. Taken together, they paint a composite picture of a system struggling to provide integrated physical and mental health care to those seeking to access to help.

Readers should note that this struggle for integrated support for PWLLE was in various instances juxtaposed against the “full-spectrum” systems of care that are in-place for other more “recognized,” socially acceptable and/or non-stigmatized forms of illness:

When someone comes through the door with a new stroke symptom, or cardiac symptom, we have algorithms, and we have ways that we respond. And we have the support system, and the finances, budgeted throughout the whole healthcare system, to take care of people [like this] to the ninth degree. But when it comes to mental health and addictions, I feel like people come in the door, and we don’t know what to offer them. There’s this big abyss, a big crack.

(Sheila Petersen—Critical Care Manager)

As discussed, not only are patients falling through cracks with respect to full-spectrum health needs, but they are often experiencing other losses: homelessness, unemployment, residential school trauma, and more. This complexity requires a multi-faceted mechanism of response of Island Health.

4.2.2. Integrate Island Health and Community services

In addition to better-integration between Island Health's acute care and mental health branches, many staff also speak to the need for greater connectivity and communication between Island Health and community care systems and institutions:

I think when people work exclusively in the hospital, what they know as to community resources is really.. it's low, and it should be boosted.... So, you know, they, they may be more aware of some of the services, but spreading that to the rest of the staff, so they know what's available, and how to access those resources, I think is really important.

(Christine McIntosh—RN, Nurse Clinician)

A range of treatment options is really important... you know, not just more detox but more residential treatment and follow through and, you know, employment programs.... Yeah, we just need to do a whole lot more.

(Deidentified Participant #15 Personal Communication)

Ideally patients seeking help could seamlessly transition between appropriate available services in an integrated healing journey. Such integration would help address a key concern raised by many about patients being "dropped":

“ We [Island Health] don't have the supports in place to support people coming out of these [detox] programs. Woohoo, they're clean, but how long is that gonna last if we don't teach them how to stay clean? Right? And I don't think two months of Rehab can teach them how to stay clean after 20 years of using, or longer for these others. ”

(Deidentified Participant #10 Personal Communication)

Several staff asked for Island Health to make progress towards a central hub of services, through a single point of access, as a way to build a reliable continuum of care:

One thing that would be really useful would be a centralized hub of all of these resources, all in one space, so that people can connect and get a great description of who's who. That's my recommendation, I don't know who would man it, but at least it's something everybody could look at and see, and find the information that they need, and find the appropriate person all in one place.

(Deidentified Participant #5 Personal Communication)

“ I feel like it would be really beneficial if Island Health would actually have all the community-based teams work out of one office. That way you have greater connections amongst the team members. You understand all the players, you understand whose doing what work, and you can better collaborate to

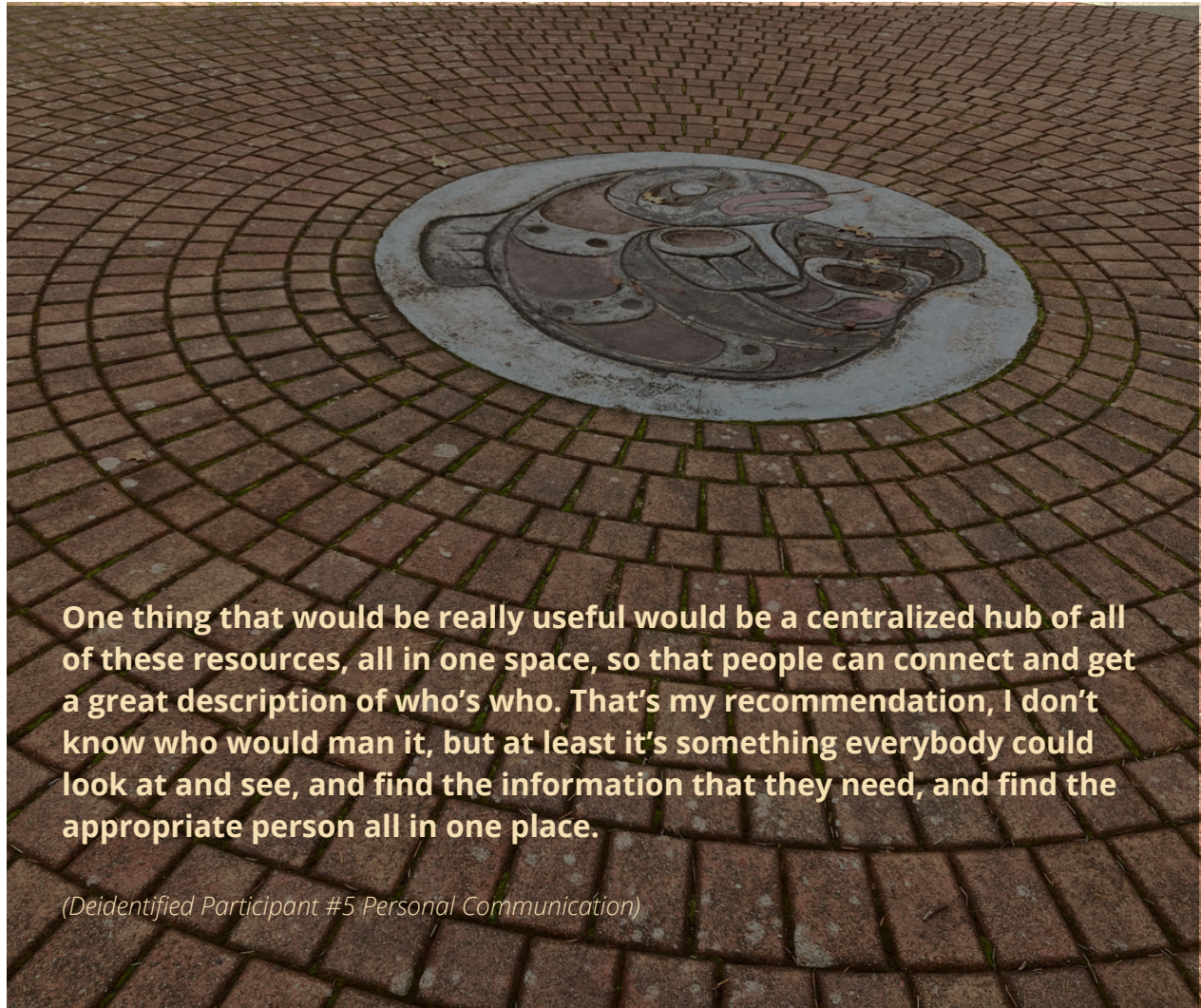
provide better care for clients. I feel like we all just need to be under one roof, and right now we're separated, and it's hard to know who is who, and what everyone does and [what are] everyone's roles.

*(Jennifer Richardson—
Community Services Coordinator)*

So, Island Health can start, please, working with other organizations. We can't do it alone, and we sure need to do it way before [clients] hit the hospital. We need to get way far upstream.

*(Deidentified Participant #8
Personal Communication)*

Others suggest a radical re-thinking of care models, such that the service parameters surrounding current health practices need re-examination (for instance, a more compassionate consideration of the requirement that people must be sober in order to access services). They felt this could help radically reduce those boundaries between mental health and acute care and community care that are not helping:



One thing that would be really useful would be a centralized hub of all of these resources, all in one space, so that people can connect and get a great description of who's who. That's my recommendation, I don't know who would man it, but at least it's something everybody could look at and see, and find the information that they need, and find the appropriate person all in one place.

(Deidentified Participant #5 Personal Communication)

In all of these comments, we see the unique physical and mental health needs of people at the heart of this crisis as being under-met by both a lack of resourcing and by structural divisions that discourage the integration of physical, mental health and community care. Staff arguments are compelling—better communication and coordination between services could produce immediate and effective results.

4.2.3 Reduce Caseloads

In addition to acknowledging the need for greater integration of services in the quest to provide better care to clients at the heart of these crises, many participants also identified their caseloads, and a false economy around "efficiency" surrounding caseloads, as a factor involved in the diminishment of quality of care. As these staff members convey:



You know... they actually fund based on minimum staff requirements. We should never be talking about minimum staff requirements, that should be not the norm, that should be unusual. We should be talking about maximum staff requirements... If you have a full well-staffed unit versus a short staffed unit, where you have then, injuries, terrible morale, lack of loyalty to the employer, and... stress leave... you then have to replace people... that is all costing. It's like doubling up what they would be paying. So I think we really have to get away from that kind of thinking where it's so dollars-focused versus "what does it take," "what would it cost to be providing quality care and supporting and fostering an environment where staff feel supported, they feel they've got backup from their manager, they feel they have the resources available to them in time as they're learning?." That is my hope for health care.



(Christine McIntosh—RN, Nurse Clinician)

In my practice [...] I don't have enough time allotted for [my] caseload, and I want Island Health to sit up and recognize that some of us... are trying to work within the system constraints but also see a broader picture.

(Deidentified Participant #10 Personal Communication)

As a nurse, I feel like we're always needing to move along and consistently be moving and the pressure [is] on that, but I absolutely love sitting and sharing space with people. Because it's only through that, that we learn.

(Deidentified Participant #16 Personal Communication)

Many expressed a desire to provide more time and energy to fewer clients who have complex mental health and addictions needs, in particular. The feeling and reality of having to "quickly move clients along" was seen as a significant inhibitor to achieving quality in care.

4.2.4 Summary

Staff insights describe fractures in Island Health's system of care, and the need for the organization's constituent pieces to come together to treat the whole patient. Work is needed to integrate disparate systems within Island Health and strengthen the ecology of services that PWLLE require for recovery through a reduction in "efficiency" logics that leave little time for deep listening, and through increased investments in a holistic, mind/body/community approach to wellness.

4.3. Unlearning and Relearning. Rebalancing and Innovation.

In this final section, we identify a strong call made by many for new systems of learning and unlearning—building on the systems change insights that staff have shared. Many staff expressed their need for support and resources to test and develop new tools to respond to the crisis. However, the need to confront old habits is concurrent to

this movement towards innovation. To begin to adequately address this crisis, staff feel that both unlearning and relearning are integral to their quest for innovation in care.

4.3.1 Unlearning and Relearning

Participants spoke to the need to unlearn prejudices imparted through dominant training processes—embedded in the assumptions, languages and frameworks at-play within these contexts.

I just wonder if there's a piece of unlearning that needs to happen, and even in the context of the schooling and education that happens in the training of healthcare providers. I think there's a lot that needs to be changed in the curriculum and how we approach human beings in providing care. It would be great to see some curriculum change to have a more human slant, and perspective, unlearning and relearning.

(Deidentified Participant #6 Personal Communication)

Unlearning involves, in this participant's view, institutional courage and bravery to make room to have difficult

conversations. It requires making safe spaces where staff can “rock the boat” without fear for their job security or a healthy working environment.

I think in order for us to move in the right direction, it takes challenging the systems in place. Because rocking the boat is scary, especially when you're a new clinician. I don't want to get in trouble, but I think it's super necessary, so I think that's something that I try to remind myself is that this process is going to be ongoing for one, and it's going to require me to allow myself to feel all the feelings; including guilt and shame and being uncomfortable and being sad. And unlearning what we have learned up to this point.

*(Deidentified Participant #16
Personal Communication)*

Unlearning also involves becoming comfortable with discomfort:

“ Change requires us to allow ourselves to be uncomfortable, and to feel guilty at times and to get into the nitty gritty, ...there's so many people that aren't going to come to this because it's almost easier to not feel that way. ”

*(Deidentified Participant #11
Personal Communication)*

Unlearning can include, accordingly, the implementation of new programs and training,

I think it's wonderful to change the larger picture. That's where that change can be sustained over the long term. But I also think that there are programs like this [Walk With Me] that can help to foster education and understanding of people's lived experience—[this] is where change at the human level can occur.

(Rebecca Peterson, Nurse Practitioner)

In particular, the implementation of more in-depth trauma-informed practice work was seen as necessary:

More education for us, is what we need. We need education on trauma informed practice, cultural safety, mental health and addictions, and we don't [get that education]. You know through nursing school, you talk about trauma informed practice for a day, you talk about Cultural Safety for a day, you touch on mental health and Addictions; but you don't really get an in depth look at that.

(Sherri Bensten—Community Health Services)

provide staff and leaders with opportunities for education. Ensuring that people are treated fairly and equitably and safely when they're encountering any part of Island Health services. So I think that's really like a foundational piece that that we've been missing for a long time and speaks to our commitments. I think that's, that's important work.

*(Deidentified Participant #11
Personal Communication)*

For one participant, Island Health's move to activate a harm reduction policy was seen as a key point of learning and organizational growth:

“ I think one of the things that I'm most excited about that island health is currently doing is actually moving towards adopting a harm reduction policy, which is a philosophy of care, really championing equitable, safe treatment for those who are using substances to hopefully change some of the experiences that people have had across our systems of care, and to

Many expressed the view that Staff should not be left on their own to make these changes. Trained Staff need a system ready to incorporate their learning.

Recognizing the disproportionate numbers of Indigenous peoples who are struggling with addictions and mental illness, cultural safety training was seen as a key component in any systemic (re)education initiative. Several participants noted that in BC, new hires from out-of-province, as well as staff from within, may have little comprehension of local Indigenous culture, protocols, or the lived traumatic history of colonization and genocide that carries an immediacy and urgency. Cultural safety training was seen as one

way to bring staff into a new awareness of the structural and cultural forces impacting those at the heart of this crisis.

I think VIHA's got this amazing idea about bringing Cultural Safety, and they recognize that they need to do it, but they're trying to put it into a system that doesn't allow for the change that's needed.

(Deidentified Participant #12 Personal Communication)

This comment speaks to the importance of coupling "training and education"

initiatives within Island Health with systems change agendas. The systems themselves, not only the staff members, must accommodate and foster learning and growth.

4.3.2 Rebalancing and Innovation

Finding equity in Island Health systems' resource allocation related to this crisis was seen as a key step in achieving a stronger institutional response. Many participants underscored the view that mental health and substance use patients were not treated equally in comparison with patients from other areas of care. Many expressed the desire to see equality in resource allocation for those at the heart of this crisis:

We provide long-term care; we will hold you in our hospital until you are end of life [...] if you need long-term care for medical, surgical reasons. But when it comes to mental health and addictions, we put [people back] on the street. They're out on the street without any support or any options, and that part blows my mind.

(Sheila Petersen—Critical Care Manager)



Various staff spoke to the reality that patients experiencing a panoply of emergency and long-term physical ailments can reasonably expect to receive appropriate and equitable support so long as their pain is derived from a non-stigmatized source. Patients struggling with addictions, mental health, and associated problems like homelessness expect to be, and are, treated as lesser, and their care is under-resourced. This lack of resourcing perpetuates a culture of second-class treatment that is dehumanizing and traumatic for staff as well as those seeking help. Further, notions of innovation are difficult to achieve within these under-resourced confines, as staff are not supported financially in developing new pathways forward.

From these insights, we see a call emerging for more comprehensive systems of learning and unlearning related to patient care. Many expressed concern with the inadequacy of current systems, and with the limitations and inequalities evident within these systems, in generating novel and innovative ways forward.

4.4. Chapter 4 Summary

New problems require new solutions, and this work requires investment. The call for Island Health to invest in unlearning and relearning is strong. Such an investment would allow the institution to challenge stigmatizing

narratives obtained by staff in their training processes, bolster their knowledge of cultural safety and trauma-informed practice, and make room for the wisdom of PWLLE to be shared in the organization's change initiatives. By investing in unlearning and relearning, Island Health invests in its capacity to imagine and innovate new ways forward.

5 RECOMMENDATIONS

Having received many insights and change ideas from Island Health staff through the research circles we've hosted, we now take a step back and again ask:

How might Island Health better-support people at the heart of the toxic drug poisoning crisis?

How might Island Health help reduce deaths, harm and stigma?

How might Island Health engage progressive forms of change leading to better health outcomes for people who use, or have used, illicit substances?

In asking these questions, we also ask: **who is responsible for making this change?**

We recognize, on one hand, the complexity of systems change, and the

need for many factions of the organization—including leaders, managers, front-line staff, etc.—to come together towards this common goal.

Yet while we recognize a shared responsibility related to this work, the recommendations outlined in this report are offered specifically to Island Health's leadership—recognizing the power that "Change Leaders" have to root values and beliefs into organizational systems, challenge the status quo, and build leadership and innovation potential within staff teams and organizational systems—leading to dramatic improvements in quality of care: The recommendations in this report recognize the power held by Island Health's leaders to create radical, meaningful, and long-term forms of systems change.²⁸

It should be noted, again, that these recommendations stem from staff participants in the Mid- and North-Island acute care facilities (Comox Valley Hospital, Campbell River Hospital, Oceanside Health Centre (Parksville)). Recognizing the localized nature of this

work, the following recommendations may have import within a wider organizational context. We suggest staff and leaders throughout Island Health assess the relevance and applicability of these recommendations to their

particular sites and contexts. Our hope is that readers consider these recommendations as fuel for the development and evolution of viable pathways forward.

1 Strengthen peer leadership within Island Health

Acknowledging:

The importance of Peer voices, leadership and stories in building empathy and compassion on a systems level, and in developing pathways leading to meaningful solutions for those at the heart of the toxic drug poisoning crisis, we recommend Island Health:

- **Undertake a strategic review of its existing Peer leadership structures to better-understand the ways in which Peers are currently contributing to the organization.**
- **Develop a strategy that increases the number of Peer leaders within the institution, and that increases the power and strategic influence of Peers - especially in areas related to staff development and education, and the institutional practices and facilities that directly impact PWLLE (ie: welcoming and discharge practices in the Emergency Department, practices involving substance prescription in-hospital, practices involving Mental Health Services for PWLLE, etc.).**
- **Pursue the guidance and best practices recommendations of Peer advocacy groups in the development and institutional supports provided to Peer leadership positions.**

2 Reduce/eliminate stigma within Island Health cultures and facilities

Acknowledging:

The existence of cultures of shame and stigmatization that persist within Island Health in relation to people who use substances throughout BC, we recommend Island Health:

- **Undertake an evaluation, along with Peer and Peer-allied leaders, of staff education, development, recruitment and evaluation practices, with an aim to support de-stigmatizing cultures, enhance staff retention, and to gather greater systemic understanding of the structural forces underlying the toxic drug poisoning crisis (ie: colonization, poverty, racism, etc.).**

3 Close gaps in the continuum of care that serves those at the heart of the Toxic Drug Poisoning Crisis

Acknowledging:

The many staff research participants that spoke to the need for stronger, more diverse and more connected services for Peers, we recommend Island Health:

- **Undertake work with Peers and front-line staff in each community in which the institution is situated to better-understand and resolve these gaps—related, in particular (but not exclusively) to detox services, OPS services and Mental Health Services, and also, to consider ways of closing**

gaps between Island Health’s services and the broader network of community support services. This work could include a ‘gaps’ analysis in each location, followed by strategic planning and action designed to fill gaps and create a stronger continuum of care.

- Undertake work, in particular, to strengthen the connections between mental health and substance use, and acute care factions of the organization
- Examine the levels of investment provided to mental health and addiction in relation to other health services, with an aim to provide equitable treatment and services to all patients.
- Encourage Island Health site leadership to network with community service leaders and to explore options for “service hubs” in each community that would bring Island Health services into stronger affiliation with a continuum of community services.

4 Strengthen ‘humanizing’ and ‘welcoming’ practices for Peers, and the ways in which the organization responds to basic human needs

Acknowledging:

The need expressed by staff for “humanizing” and “welcoming” protocols that express support and appreciation for PWLLE seeking services (especially PWLLE who are unhoused), we recommend Island Health:

- Examine and re-think existing protocols that address basic needs of unhoused PWLLE entering Island Health facilities—related, for instance, to food, dry clothing, and a place to warm up.

5 Reduce caseloads

Acknowledging:

The need expressed for staff to take more time per client to better-understand client needs and improve quality of care, we recommend Island Health:

- **Pursue practices of "excellence in care" that move beyond a market-based efficiency model, and that adopt a philosophy of care rooted in client need.**

6 Make space for critical thinking, learning and innovation—on both an individual and systems level

Acknowledging:

The need expressed by numerous staff for increased "unlearning" and "relearning" initiatives that drive innovation and change, we recommend Island Health:

- **Support the strong inclusion, in the day-to-day work of staff, of critical thinking, group development/education and group strategic conversation—with an aim to re-examine and re-develop core care practices in such a way as to better-support those at the heart of the crisis.**

- **Foster a culture in which staff innovations are valued and encouraged (allow for boat-rocking that challenges the status-quo and opens up new potentials in care)**
- **Support education and staff engagement mechanisms designed to improve systems**
- **Foster a culture in which staff teams are invited to re-think core care processes with an aim to create stronger systems of care**
- **Increase educational offerings related to cultural safety and trauma-informed care**

These recommendations offer various pathways forward, and together create a "potentials framework" intended to be used by institutional leaders to make progress in improving Island Health's response to the toxic drug poisoning crisis.

6 CONCLUSION

In this report, we've explored key factors contributing to the growth of the toxic drug poisoning crisis nationally and in BC. and have acknowledged key counter-measures being taken by the Provincial Government, and by provincial health systems, including Island Health, to address the crisis.

We acknowledge, as well, the reality that toxic drug-related fatalities continue to climb. Urgent action is needed beyond the initiatives currently being taken to stem the wave of death, and improve the quality of care for those facing the impacts of this crisis directly.

The Walk With Me team has been honoured to sit in-circle with Island Health staff from Campbell River Hospital, Comox Valley Hospital and Oceanside Health Centre (Parksville), and to receive powerful insights gifted with intent to make change. From these sessions, we've been honoured to present a series of findings and recommendations which, along with other emergent forms of knowledge, offer a framework for strategic action.

In closing, we wish to recognize and honour all who gave their voices within this process; those we've had the honour to walk alongside. It is by asking difficult questions, exploring tensions, and convening together to explore pathways forward, that a hope for change is made possible.

APPENDIX A

This Appendix is intended to offer greater background information to those seeking to learn more about the toxic drug poisoning crisis and the context in which Walk With Me is working. Among many documents that summarize the situation,⁷ this Appendix represents an update and expansion on some of the materials in Walk With Me's 2021 Policy Report for the Comox Valley.²⁹

A. History

For the first time in BC's history, in April of 2016 the province's Health Officer declared a public health emergency under the Public Health Act—a designation that continues today. BC³⁰ has the highest provincial per-capita rate of apparent illicit drug toxicity deaths.^{31(pp21)} Since 2016 there have been over 10,000 deaths and the rate of toxic drug-related deaths for this period has climbed to higher than three times the combined unnatural deaths from suicide, motor vehicle incidents and homicide.^{32,1(pp4)} Between April and November, 2020, the number of deaths in BC resulting from toxic drug deaths

(1,279) was almost triple the number of deaths resulting from COVID-19 (432).⁷

The Province's move to label the toxic drug poisoning crisis a provincial public health emergency was a first in BC and Canada and triggered a multi-faceted intervention aimed to save lives and reduce harm.^{34(pp3)} Elements of this intervention include: public education, targeted information campaigns, connection with people with lived and living experience, increased access to treatment for opioid use disorder, distribution of naloxone to reverse toxic drug poisoning, passage of legislative changes, increased toxicological testing of drugs, expansion of harm reduction services (ie: the establishment of toxic drug poisoning prevention services and expansion of supervised consumption sites), the development of a ministry focused on mental health and addictions, enhanced pharmacological treatment using OATs (Opioid Agonist Therapies), and mental health treatment in the form of trauma and mental health counselling, etc.^{7,34(pp3)} These interventions were claimed by the Province in 2019 "to have averted 60

per cent of all possible overdose deaths since the declaration of the public health emergency."^{34(pp3)} Despite laudable efforts, the Province consistently sets a new record in total toxic drug-related deaths each subsequent year and is on course to continue to do so with 2022.

There was, however, one exception to this trend that occurred in 2019 when the province's total illicit drug toxicity death number fell for the first time since 2012.^{35(pp3)} Total illicit toxicity deaths fell to 984 (2019) from 1,549 (2018)—possibly due to the above interventions.^{36(pp3)} Yet the COVID-19 pandemic appears to have counteracted this reversal, with toxic drug death counts rapidly more than doubling from April through November, 2020, in comparison to the same time span the previous year.^{36(pp3)} The pandemic has been identified by numerous experts, including BC's chief coroner, Lisa Lapointe, as having significantly exacerbated the crisis.³³

As recorded in the month of May 2022, British Columbia's unregulated illicit toxic drug supply was claiming the lives of an average of 6.3 people every day.³⁷ There are a multitude of long-lived harms to individuals, families, workers, institutions, and social systems that persist in association with these deaths. The magnitude of such harm is difficult to measure. These recorded deaths index significant pain for many

connected to the deceased—as family members, friends and colleagues. The rising figures suggest immense risk for current illicit drug users, and describe an increasingly heavy burden carried by health agencies providing support to those at the heart of the crisis, including Island Health.

Increases in record-setting death-rates are explained in part by the evolution of novel illicit drugs. It's an arms race. Illicit drug producers are motivated to create ever more concentrated and inexpensive drugs that adapt to the current capacity of prohibition policies to detect, criminalize, and abolish illicit drug supply. In January 2022, illicit drugs were showing concentration levels of benzodiazepines in 52% of tested supply, up from 15% in July 2020.³⁸ Because benzodiazepines are not opioids, naloxone—which is designed to target and block the depressive reparatory effects of opioids—can prove less effective in mitigating drug poisoning fatalities. Benzodiazepines add significant new life-saving challenges for first responders. The complexity of the supply chain, where trafficking rapidly responds to policing and demand, illustrates how prohibition-derived solutions based on social assumptions about latent desire for enforcement and social stigma—as justification for criminalization—produce ever more-deadly results. As has always been the case under the constraints of prohibition, illicit drug

supply and demand evolve at a faster rate than the existing tool kit can respond. Prohibition-derived policies force Island Health workers to endure the predicted consequences of BC's toxic and poisoned drug supply.

B. Locating Impact

The manner in which we understand impact is informed and limited by what data the Province, Vancouver Island Health Authority, First Nations Health Authority, the BC Coroners Service, BC Centre for Disease Control and other health, government and community service agencies determine to collect and earmark as relevant to the crisis. This sub-section reviews some of the key statistics emerging from the provincial public health emergency.

B.1 Who is Most Impacted by this Crisis? (Demographics/ Characteristics)

How one answers the question, "who is most impacted?" defines an understanding of the crisis and shapes public policy and systems change strategies. The answer directs community action. Here are some key demographic-based findings:

- **The crisis disproportionately impacts middle-aged men.** In 2022 from approximately 1830 deaths, 73% of those dying of intake of toxic drugs in BC were between

ages 30 and 59. 37% were at least 50 years old. Males accounted for 76% of deaths.⁷ Similar figures are reported for 2016–2020.^{35,36,39}

- **The crisis disproportionately impacts Indigenous People.** Approximately 15% of toxic drug poisoning deaths in BC since 2020 have been First Nations people and yet First Nations represent 3.3% of the province's population.⁴⁰ In 2021, First Nations people were represented approximately 17% of all recorded toxic drug events for Island Health where they make up only 4.2% of the population.⁴
- **Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in toxic drug statistics.** While the toxic drug poisoning crisis at-large in BC disproportionately affects men, First Nations women died from exposure to toxic drugs at 9.8 times the rate of other women in BC.⁴
- **The crisis disproportionately impacts people who are unemployed, as well as people in the trades and transportation industries.** A study of 872 toxic drug deaths in BC from 2016 & 2017 shows that most people who died from poisoning were

unemployed (51%). Of those employed, 55% were employed in the trades and transport industry.^{41(pp5)}

- **The crisis disproportionately impacts people who are grappling with pain and mental health issues.** The same study shows 79% of toxic 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.^{41(pp5)}
- **Most illicit and toxic drug deaths occur in private residences.** The above-mentioned study from 2016 & 2017 shows 72% of toxic drug death victims as having lived (and died) in private residences, thirteen percent as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.^{41(pp5)}
- **Most toxic drug victims are not married.** Sixty-Five percent of those who overdosed or died in the study had never been married.^{41(pp5)}

- **Most overdose toxic drug victims use drugs alone, rather than with other people.** The majority of those who overdosed or died (69%) had used their drugs alone.^{41(pp5)}
- **Toxic drug poisoning increases during income assistance payment week.** A BC Coroners Service Report analyzing data in 2019 & 2020 shows the daily average of toxic drug deaths in the province as having risen from 4.2 to 5.4 in the four days following income assistance payment day (Weds – Sun) (BC Coroners Service, 2020a, p.8).^{36(pp8)}

These statistics help form a demographic profile of toxic drug crisis victims that, though limited in scope, helps to inform understanding. From them, we understand this crisis as most severely impacting middle-aged men and Indigenous peoples, especially Indigenous women. First Nations people continue to be disproportionately impacted by drug toxicity related harms and deaths in British Columbia and more specifically in the Island Health Authority Region. The conditions that inform First Nation's experience of addictions, mental health, and homeless are unique and profound, and they are rooted primarily in attempted colonial dispossession. They reflect the failed attempt of the British Crown and Canadian Government to systematically erase Indigenous agency, culture, and

people while claiming and colonizing their land and way of life. During this state of emergency in British Columbia, First Nations continue to confront the consequences of attempted colonization, the Residential School system, the Indian Act, and the countless racist and discriminatory policies and histories that inform their intergenerational trauma. Quoting BC's *In Plain Sight* report, "Widespread racism has long been known by many within the health care system, including those in positions of authority, and is widely acknowledged by many who work in the system."^{25(pp8)} It is critical to acknowledge these historical injustices have had in relation to First Nations communities' experience of the crisis.

We also see the crisis' inordinate impact on those with pain management and mental health issues, often labourers who have suffered accidents or work-related trauma and had been prescribed opiates, and we observe an inverse correlation between toxic drug poisoning rates and income, recognizing a higher rate of death amongst those who are unemployed and accessing income assistance. People from all walks of life are impacted by this crisis. Recognizing this fact, readers should read these statistics with the awareness that only tell a part of the story.

B.2 Where is this crisis unfolding? (Rural vs Urban)

Contrary to public imagination and reputation, the crisis is not confined to large urban centres. For example, per capita, BC's highest rates of toxic drug deaths are in the Northern Health Authority in 2022.^{1(pp1)} Overtime, Central Vancouver Island has joined Vancouver City and the BC Interior with the highest rates per-capita of toxic drug poisoning deaths in all of the province.⁴² Opioid use and toxic drug deaths in small cities and towns are growing, and in some cases surpassing growth rates in large urban centres. 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."⁴³ 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 overdose events."^{44(pp8)} 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 toxic drug poisoning calls to 911. Some of the highest increases in toxic drug poisoning calls were found on the BC coast and in small cities on Vancouver Island.^{45,46} These statistics

challenge the view that the toxic drug poisoning crisis resides in large urban centres.

B.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 May 2022, Island Health recorded 1,579 illicit toxicity deaths, approximately the same number as Interior Health, third behind Vancouver Coastal and Fraser.^{1,36(pp12)}

At first glance, large urban centres may appear to be experiencing the worst of the crisis, however, when examining drug toxicity deaths as occurring as a per-capita rate (per 100,000 people), we see the highest illicit drug toxicity death rates in 2021 on Vancouver Island were to be found in North Vancouver Island (48.5), then Central Vancouver Island (41.1), and finally South Vancouver Island (32.6)—today we see Central Vancouver Island surpassing North.^{47,42} While a longer view from 2016 to the present suggests that Central Vancouver Island consistently has higher figures, if current trends continue, Central and North Vancouver Island rates will soon double the urban Victoria region.¹

This data clearly demonstrates that the per-capita impact of the crisis is higher in the small cities of Campbell River, Courtenay/Comox, Nanaimo and

Duncan, than in Victoria and its surrounding areas.¹ It follows that proportionally, the crisis is costing institutions and individuals far more outside of the capital region.

B.4 How is the Crisis unfolding in the North Vancouver Island?

Within North Vancouver Island HSDA, toxic drug poisoning is concentrated in the Comox Valley Local Health Area (Comox Valley) and Greater Campbell River Local Health Area (Campbell River). In terms of number of deaths, 270 illicit drug toxicity deaths in total that occurred in in the North Island HSDA since 2016,⁴⁷ we see the two communities, Comox Valley and Campbell River, as having similar numbers of toxic drug poisoning, with Campbell River leading slightly.

When examined in rates of death versus total death counts, the average rate (per 100,000 people) of toxic drug poisoning deaths in Comox Valley between 2017 and the present (21.26/year) is almost half that in Campbell River for the same time period (41.73/year).⁴⁷ The fact that Campbell River has a lower population than the Comox Valley reveals a significant difference between the communities in their per-capita toxic drug poisoning rates. From this vantage-point, Campbell River's experience of the crisis is much more dramatic than the Comox Valley's.⁴⁸

Such analysis should recognize the dangers of conceiving of toxic drug death rates and substance use diagnoses as indicative of the full scope of the crisis. It is common for people with opioid use disorder to have multiple morbidity factors, and their deaths to be classified in ways other than as "illicit drug toxicity". Furthermore, while these numbers help to inform our understanding, it is important to recognize that the toxic drug poisoning crisis cannot be fully understood through numeric representation. This is a human crisis, one that while producing some statistical markers, cannot be adequately expressed or understood through statistics alone.

C. What are Key Contributing Factors?

To date the toxic drug poisoning crisis has been fuelled by a "perfect storm" that includes an increase in toxic supply of 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 the erosion of mental health supports and erosion of education supports create a landscape that fosters the toxic drug poisoning crisis.

C.1 Increase in Toxic Supply / Provision of Safe Supply

Fentanyl holds the lead role in driving the 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.⁴⁹ It is also made and distributed illegally through various supply channels. Concentrated drugs ordered online from outside the country are distributed through decoy packages sent by mail or courier in small quantities to evade detection by Canada Border Services Agency where Canada's Boarder Services Agency currently requires a supplier's permission to open packages weighing less than 30 grams.⁵⁰ Fentanyl traffickers range from organized crime operations to lone operators. Once the drug is in the country, it is diluted in clandestine labs, 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.⁵¹ 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."⁵¹

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. “Overdose Alerts” issued by Health Authorities have become common in BC.⁵² 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.^{53,54} Over the past 9 years in BC, fentanyl has been detected greater numbers of apparent illicit drug toxicity deaths. While this rate stood at 4% in 2012, by 2021 it had increased to a staggering 86%. Notably, the closure of borders brought about by the onslaught of COVID-19 pandemic complicated drug supply chains and has resulted in increased toxicity of supply.⁵⁵

While more fentanyl is crossing into Canada and is linked to the rise in toxic drug deaths, new and even more dangerous illicit street drugs are also entering the scene. Carfentanil and W18, both of which are more powerful than fentanyl, carry a high risk of death.⁵⁶ Methamphetamine use is also on the rise in BC's supply—a stimulant that is regularly cut with fentanyl and other toxic substances.^{36(pp17)} Benzodiazepines (commonly prescribed to treat anxiety and depression) are increasingly added in problematic ways to fentanyl and other illicit drugs and are associated with increasing numbers of toxic drug deaths.⁵⁷

C.2 Safe 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.”³⁷ These guidelines, which allow certain eligible populations of drug users to access prescription drugs from limited classes of health professionals, are designed to help stem the risk of increased toxicity death brought about in part by the pandemic.⁵⁸ In September 2020 these guidelines were expanded under a public health order from provincial health officer Dr. Bonnie Henry to provide Safe Supply access to nearly all people who access the street drug supply.^{59,60} The new guidelines also allow for registered nurses and psychiatric nurses to prescribe controlled substances under specific restricted conditions and requirements. Safe Supply is slated to become more available at the start of 2023. The roll out of this landmark initiative has encountered various “bottlenecks”—namely under-resourcing and the challenge of construction of new protocols and systems. The public is impatient to see real change, and experts are challenging the government's claims of progress to date.⁶¹ Delays were not unexpected as “BC [is] the first province or territory in Canada to pursue safer supply so aggressively.”⁵⁹ BC's former Minister of Mental Health and Addictions, Sheila

Malcolmson committed publicly to creating Safe Supply programs across the province. The realization of these commitments is taking time.

C.3 Opioid Agonist Therapy

Safe Supply is in part an extension of Opioid Agonist Therapy (OAT)—a treatment strategy that has been in place within BC for many years (since 1959)^{62(pp444)} that involves prescription of opioid agonists such as methadone (Methodose) and buprenorphine (Suboxone) which are long-acting opioid drugs provided in daily doses used to replace shorter-acting opioids such as heroin, oxycodone and fentanyl. 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.^{62(pp448)}

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.^{8(pp1)} A recent meta-analysis demonstrated that retention in OAT is associated with two to three times lower all-cause and toxic drug-related mortality in people with Opioid Use Disorder.^{63(pp2)} However, significant barriers to uptake and retention exist including the quality of OAT service provision.^{64(pp91)} Improvements to

quality of OAT delivery, incorporative of best practices guidelines, can positively impact uptake and retention of this service.⁶³ Recognizing the role OAT plays in preventing toxic drug poisoning deaths, work is needed to systemically upgrade service delivery systems throughout the province.

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 counsellors (with specific methadone expertise), social workers, probation officers, community mental health liaison workers, etc.”^{65(pp81-82)} In large urban centres, the integration of such “wrap-around” support services is often more fluid than in small, due to the paucity [in small/rural centres] of health professionals and services...^{62(pp446)}

Furthermore, OAT delivery in Canada is tied to contingency management strategies that allow for increasing number of doses to be taken home by patients. “Carry privileges” are increased “based on appointment attendance and consistently negative urine screens for opioids, stimulants, and other substances”.^{62(pp447)} 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. While OAT and Safe Supply are strategies often championed for their capacity to counterbalance the rising toxicity of the street drug supply, barriers currently exist that limit their effectiveness, especially in rural and remote communities.

C.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.¹² This is in part due to a liberal approach to the prescription of pain medication.^{62(pp446)} National clinical practice guidelines published during the early days of the crisis, the *Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain*⁶⁶ 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.”^{56(pp659)} Between 2010 and 2014, opioid prescribing across Canada increased steadily by 24%, with 21.7 million prescriptions dispensed nationally in 2014.^{62(pp446)} This increase in prescription rates resulted in a “massive swell” in opioid dependency.^{62(pp446)}

Regulatory bodies have been working to come to terms with the damage associated with rising opioid dependency to address the crisis. 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.”⁴³ 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. The response has been fragmented as key elements of health regulations and policy are not provincially and nationally harmonized.^{68(pp1)}

In spite of this fragmentation, government initiatives to restrict opioid prescription have been 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. However, by adding deterrents to opioid prescription practices, the measures were also seen

to increase demand for toxic street supply, as regular opioid users denied pharmaceutical supply were in many cases compelled to seek illicit supply from the street.¹³

There are a multitude of systemic factors driving individuals towards dangerous substances including: changes in the illicit drug market's production practices that resulted in increased toxicity of street supply; bottlenecks in government response mechanisms (OAT and Safe Supply) 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.

C.5 Criminalization

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

The *Opium Act* of 1908 establishes the legal framework for Canada's drug control policy⁷⁰ as well as alcohol, tobacco and medicine regulations. This act developed as part of a nation-wide attempt to control non-British immigrant populations and to uphold a

white bourgeois order.^{71(pp458)} In 1911, the *Opium and Drug Act* added other opiates and cocaine to the list of prohibited substances. In 1923, cannabis was added.⁷⁰ The ban on alcohol and tobacco was 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."⁷² However, his government's and those that followed into the first decade and a half of the 21st century advanced policy in direct opposition to this commission's recommendations. The most recent and memorable prohibitionist impulse 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"^{71(pp123)}, a claim that was counter to both evidence and popular sentiment. In 1987 the government announced the *Action on Drug Abuse: Canada's Drug Strategy*—which "brought \$210 million

in new funding" into play in the nation's fight against drugs.⁷³ A substantial portion of these funds were earmarked for enforcement.^{74(pp2)} In 1996, the *Controlled Drugs and Substances Act* was passed—a substantial piece of legislation that "expanded the net of prohibition further still."⁷³ And in 2007, the Harper government released the *National Anti-Drug Strategy*, which removed the harm reduction pillar from the nation's drug strategy⁷⁵ and emphasized "busting drug users [rather] than helping them."⁷⁶ This framework of increasingly prohibitionist legislation led to a situation in which drug arrests in Canada totalled over 90,500 in 2017: over 72% of which were for drug possession.^{77(pp1)}

The lasting rhetoric and propaganda of the War on Drugs has exacerbated Canada's drug issues. Its punitive approach to people who use substances resulted in the most severe penalties in the country's criminal code "surpassed only by offences such as assault or murder."^{78(pp65)} 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."^{79(pp263)}

The enforcement costs of the war were estimated at over \$9 billion and include the erosion of Canada's invaluable civil liberties.^{80,81}

Drug enforcement policy has never been applied to all citizens equally.

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.⁷⁸ "Drug enforcement [he argues] became an excuse for the police, in their pursuit of the production of bourgeois order, 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."^{78(pp68)} The Drug Policy Steering Committee for Toronto Public Health,⁸² adds weight to this argument, noting that the federal government's 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."^{82(pp2)} There are numerous studies that demonstrate that these laws are used to enforce systemic forms of anti-Black, anti-Indigenous and anti-immigrant racism (*The Impact of Mandatory Minimum Penalties (MMP) on Indigenous, Black and Other Visible Minorities*) produced by the Department of Justice Canada.⁸³

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.”⁷³ Canada by contrast continued up until 2016/2017 to develop and enforce prohibition-based drug laws.

Throughout this time-period Canada’s solidly prohibitionist stance was publicly, politically and legally challenged, and would cede periodic “allowances.” Such an allowance occurred in 2003 when Health Canada under the Liberal Government granted the Vancouver Coastal Health Authority a limited exemption from Canada’s drug possession and trafficking laws under the *Controlled Substances Act*, towards the opening of North America’s first safe injection facility in Vancouver—InSite.⁸⁵ Another allowance is found in the government’s efforts in 2016 and 2017 to allow for, and streamline, exemptions to the *Controlled Drugs and Substances Act* for toxic drug poisoning prevention sites.⁸⁶ These allowances when positioned against the backdrop of over a century of prohibitionist legislation appear as the first “trickles” in what would 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.⁷⁵ In 2017 the *Good Samaritan Drug Overdose Act* became law, providing protection to people who witness overdoses “so that they can seek help, and ultimately save lives.”⁸⁷ 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 the first G7 economy.⁸⁸ 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 debate continues through its Second Reading. Among other things, this bill aims to “repeal certain mandatory minimum penalties (including those instated by the Harper government); allow for a greater use of conditional sentences and establish diversion measures for simple drug possession offences.”⁸⁹

These moves by the Trudeau government towards an anti-prohibitionist stance towards illicit substances mark a stark contrast to the staunch prohibitionist stance taken by the 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 toxic drug poisoning since 2016,⁹⁰ these steps are seen by many

as too little, and too late.

C.6 Failure 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” (Drug Policy Steering Committee, 2018).⁸²

Multiple sectors have asked federal government to do more and move faster in pursuit of decriminalization since 2016. Decriminalization frames drug-use as a public health issue rather than as a criminal justice issue. 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 small amounts of illicit substances for personal use are supported with community resources rather than prosecuted.

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.”⁹¹ 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.”⁹²

An increasing number of high-profile players are among Canada’s advocates for decriminalization. Notable bodies include:

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.”

2019 (April):

BC’s Medical Health Officer publishes report *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*, again advocates for federal decriminalization of personal possession.³⁴

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 decriminalization for simple possession identified as an effective way to reduce the public health and safety harms associated with substance use.^{93(pp2)}

2020 (July):

BC's Premier John Horgan formally asked the federal government to decriminalize possession of illegal drugs for personal use.⁹⁴

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.⁹⁵

2021 (October):

BC's Ministry of Mental Health and Addictions formally applies for decriminalization exemption.⁷⁵

2022 (May):

The exemption will be allowed in all of BC from January 31st, 2023 to 31st 2026. While an enormous win, the slow speed of change is disheartening, and what is being permitted as is so restrictive that the gains feel quite limited.⁹⁷

The voices advocating for decriminalization have exerted considerable pressure on the federal government to bring us this far. Along with skyrocketing toxic drug poisoning fatalities, which are contributing to a

shift in public opinion, these voices are exerting a push against which the federal government is slowly responding.

Some advocating for steps beyond decriminalization, such as the Canadian Drug Policy Coalition through its Regulation Project,⁹⁸ 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, and made subject to federal production and distribution laws. Proponents of legalization tout its capacity, beyond that of decriminalization, to establish a system of “regulated purity,” enact age restrictions on 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.”⁹⁹ Legalization is critiqued by some for its potential to increase drug use produce harms similar to those 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.”¹⁰⁰ This argument is difficult to prove as currently there are no countries that have legalized hard drugs. Given this situation, decriminalization represents a proven first step in addressing the toxic drug poisoning crisis from a policy lens.

D. Upstream Services - Social Determinants of Health

Numerous "upstream services" also contribute to the crisis. Lack of affordable housing, lack of access to quality Mental Health Services, and lack of quality of education: these are all exacerbating the crisis. These areas broadly represent the wages of "hypercapitalism" and modern social alienation. The subjects we touch on are by no means a definitive list but represent entry points for a systems-based understanding of the crisis.

D.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 time 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.⁸⁰

While Vancouver and Toronto, as global cities, were "the first to catch the bug of extreme housing speculation," the crisis was to 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."¹⁰² In the Comox Valley, the benchmark price of a single family home was \$911,700 as of June, 2022,—in March of 2016, the benchmark price was \$354,100, an increase of 160% in 7 years.¹⁴ In Campbell River, the benchmark price of a single family home was \$761,800 as of June, 2022, and was \$281,800 in March of 2016, a 170% increase.¹⁴ Housing unaffordability is directly contributing to the exacerbation of health determinants, 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."¹⁰³ 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 annually for each person provided with housing in the long run.¹⁰³ A similar program in Medicine Hat, introduced in

2009, has also led to significant progress indicated by their having helped formerly homeless individuals including 995 adults and 328 children since 2009 with associated “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.”¹⁰⁴

D.2 Mental Health Services

In 2006, Rural BC was acknowledged to suffer from a “severe shortage of Mental Health Services”¹⁰⁵ —a reality recognized again ten years later.¹⁰⁶ A 2019 BC Coroners Report¹⁰⁷ and report from the Office of the Provincial Health Officer¹⁰⁸ also confirmed this gap. The Province in its 2021 budget committed to providing \$500 million in new funding for “expanded mental health and substance use services”¹⁰⁹ including \$152 million for opioid treatment—the largest increase in mental health in the Province’s history.¹¹⁰ This funding acknowledges both the growing gaps in Mental Health Services at-play within the Province as well as the link between mental health and the toxic drug crisis. It is a positive step forward with results to be determined.

D.3 Education

Beyond housing and mental health, (lack of) education plays an important contributing factor in the toxic drug

crisis. The Province is suffering a crisis in education. BC invests less than any other province in its elementary and secondary students.¹⁶ While funding for public education significantly increased in 2017-18, “government spending on K-12 education as a proportion of total public spending continues to decline.”¹¹¹ Simultaneously, the “costs of running the public education system have continued to rise and expectations of schools have increased significantly.”^{112(pp19)} These fiscal challenges have resulted in the loss of supports for students, including specialist teachers (individuals who provide additional layers of learning and social support, address diverse needs of students and are seen as markers of inclusivity)—the number of which has declined drastically in recent years.^{17(pp10)} The lack of learning specialist teachers is acknowledged as “particularly acute in smaller communities and remote schools.”^{17(pp10)}

The toxic drug poisoning crisis and the educational environment in BC are linked in several ways. Children and adolescents who grow up in households with drug use may experience adverse consequences including: “increased risk of mental health problems and drug use; accidental opioid poisoning; increased risk of developing a substance use disorder; and family dissolution that results from parents’ incarceration, foster care placement, or loss of parent to an opioid overdose.”¹¹³ Given the

educational funding crisis outlined above and the fact that this crisis has removed supports for vulnerable students, the school system is challenged in its ability to meet children's needs. Further, children and adolescents who face challenges besides those related to the toxic drug crisis, including those stemming from poverty, mental health, etc., also run the risk of being left behind without the provision of adequate supports and of developing learning and social deficits that impact them later in life. These children are at greater risk of social destabilization and of suffering from challenges related to mental health and addiction.

In recent years, the BC. school system has worked strategically to develop new models of learning—the most recently-developed curriculum places significant emphasis on core competencies: “sets of intellectual, personal, and social and emotional proficiencies that all students need in order to engage in deep, lifelong learning”¹¹⁴ Here, teachers are encouraged to enable students to explore and develop social emotional and behavioral competencies, including such skills as communication, conflict management and self-care. Through this focus, children and adolescents are equipped, perhaps better than before, to activate the tools at their disposal when engaging in adverse life events and trauma. However, with sub-average funding,¹⁶ BC’s education system will be challenged to attain these goals.

D.4 Hypercapitalism and ‘Poverty of the Spirit’

Vancouver-based psychologist Bruce Alexander made headlines with his book *The Globalization of Addiction: A Study in Poverty of the Spirit*.¹¹⁵ 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 a quintessentially ‘globalized’ 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 and rationality of hypercapitalism—that are ubiquitous in cities throughout the globe and are consistently propagated through globalized mass media—are responsible for a mass “impoverishment of the spirit” including an impoverishment of community and of the connections that bind individuals together. His argument posits the importance of belonging and collectively-defined purpose as a core human need, one that when not filled can result in profound dislocation and in attempts to “fill the gap” through alternate means. When market forces

are left unchecked, they lead (in addition to ecological devastation) to widespread dislocation, and to the proliferation of addiction as a coping mechanism.

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: "...ultimately I'm saying that illness in this society, by this society I mean neoliberal capitalism, 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."¹¹⁶ 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 more global perspective, addiction can be reframed 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 are able to find connection within hypercapitalism and others can cope with it. But for a portion of the population, the response to our widespread erosion of social fabrics occurs in the form of addiction

(including drugs and alcohol, but also addiction to shopping, gambling, working, exercising, power, money, perfection etc.). When unchecked, these habits serve to temporarily fill the void left by a society consumed with free-market logics at the expense of human connection. 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. Such a goal Alexander sees as foundational to not only addressing the root cause of addiction, but also, to the goal of bringing people together in profound and innovative ways in addressing other key crisis endemic to our time.

D.5 Island Health – Efforts

Island Health holds a leadership role in confronting the crisis with action. Island Health staff recognize this, and our research confirms and applauds these efforts. Island Health leadership and staff agree that more must be done and that meaningful change will take considerable effort.

Working within current constraints, Island Health continues to take up numerous efforts including the following recent initiatives to combat the crisis:

1. Learning about Opioid Use Disorder, “LOUD in the ED,” has made big waves in the Campbell River emergency department as Chapter 3 will discuss. LOUD in the ED began as a pilot program that the BC Patient & Quality Council led in delivering in partnership with the Overdose Emergency Response Centre and BC Centre on Substance Use from October 2020 to March 2021. The program recognizes that 21% of people with Opioid Use Disorder experience their first point of contact with the medical system through an emergency department (ED). Therefore, the ED represents a very unique space in which to make a first impression and take critical action to make a difference in the toxic drug poisoning crisis.

LOUD in the ED began by gathering “Twenty-five teams from across the province engaged in learning and application of change ideas related to clinical practice, education, person- and provider-centred care and connections to the community.”¹¹⁸ The program was focused on creating an environment in which all people feel safe to seek help from the medical system.

In Campbell River, follow-through on the program includes placing People With Lived/Living Experience of the experience—Peers—on the

Emergency Department floor to help to support incoming patients with addictions and mental health needs.¹¹⁹

2. Preparing for, budgeting for, and issuing Requests for Proposals to provide Overdose Prevention Services like Prescribed Safe Supply, Safe Injection and Inhalation Sites, and Opioid Agonist Therapies (BCBid).¹¹⁷

3. Launching a campaign to support those who use substances, targeting men aged 30-59 who represent the majority of toxic drug deaths.¹¹⁸

4. Recognizing that education for youth is critically important in addressing the crisis, Island Health is exploring novel partnerships like a new mobile service van for youth wellness.²³

5. Developing, releasing and implementing an Island Health wide “Harm Reduction — Substance Use” policy that directs required organizational practice and behaviour: “The aim of this policy is to promote a health care approach that is without stigma related to substance use.” This policy outlines significant aspirations and establishes strong evidence-based expectations for baseline care with respect to values and quality of service delivery. The policy

represents a tangible composite reference point for progress against which Island Health can now begin to measure its harm reduction work—Island Health staff and leadership can “test” their harm reduction informed decisions and actions against the expectations in this policy to see if they are retrogressive, aligned, or exceptional.

6. Contracting Walk With Me and other community organizations to advance harm reduction training and knowledge sharing within Island Health staff team.

Walk With Me honours the spirit of trust and desire to do better that Island Health’s leadership demonstrates through these initiatives. The speed of change required from Island Health and society to meet the crisis asks for more than incremental steps, but rather, giant and bold leaps; and radical forms of systems change.

E. Appendix Summary and Conclusion

This Appendix reviewed key contributing elements to the toxic drug poisoning crisis in Canada and BC. It acknowledges the dramatic increase in toxic drug deaths brought about since 2016 when the crisis was labeled a provincial public health emergency, and we have seen how the crisis has unfolded statistically

in Island Health, the North Island Health Services Area, and in the Comox Valley and Campbell River Local Health Authorities. Toxic drug deaths are fueled by a number of factors: increased toxicity of supply brought about by a rise in fentanyl production and distribution; trends in over-prescription of opioids and subsequent attempts to curtail such prescription—an act that drove many to the illegal market; the rise of the Covid-19 Pandemic; and a regulatory environment rooted throughout the 20th Century and into the 21st in a firmly prohibitionist stance. We’ve considered the development of a slate of counter-measures within Canada broadly and BC in particular designed to combat fatal toxic drug poisoning death: Safe Supply, Opioid Agonist Therapy, toxic drug poisoning prevention sites and interventions, and in recent years, the relaxation of federal and provincial drug legislation. We’ve outlined a growing movement, fuelled by a spike in toxic drug deaths that has stunned the nation, and championed by key advocates such as BC’s former Premier John Horgan and the Canadian Association of Chiefs of Police, advocating for an entirely new federal regulatory paradigm and approach to drug enforcement. And finally, we’ve touched on the role played by the “social determinants of health” and by hypercapitalism in exacerbating the crisis.

We have also reviewed examples of what Island Health has been doing to address the crisis. Walk With Me hosts and fosters brave conversations, and our readers can now return to the body of this report to gain further insight from those staff from Island Health who shared their voices with us.

24

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