DELEGATION REQUEST

Names of persons speaking:
Sharon Karsten, Barb Whyte, Sam Franey, Sophia Katsanikakis and Darcy Honey

Organization you are representing: Walk With Me

Primary purpose of the organization: Addressing the toxic drug poisoning crisis in our community

Number of members: 10

Contact name: Sharon Karsten

Subject matter:
Presenting the Walk With Me Policy Report - Uncovering The Human Dimension of the Drug Poisoning Crisis in small BC Communities. We are presenting in partnership with the Substance Use Strategy Committee as we are working together to address Phase Two of this work.

Specific request of the regional district, if any (i.e. letter of support, funding):
To come on a Walk with our group

Requested meeting date: November 9th

WALK
WITH
ME:

The crisis disproportionately impacts middle-aged men. In 2021 (up to January 31), 70% of those dying of drug poisoning in BC were between ages 30 and 59. Males accounted for 83% of deaths. Similar figures are reported for 2016 - 2020. [14] *(See figure 1)*

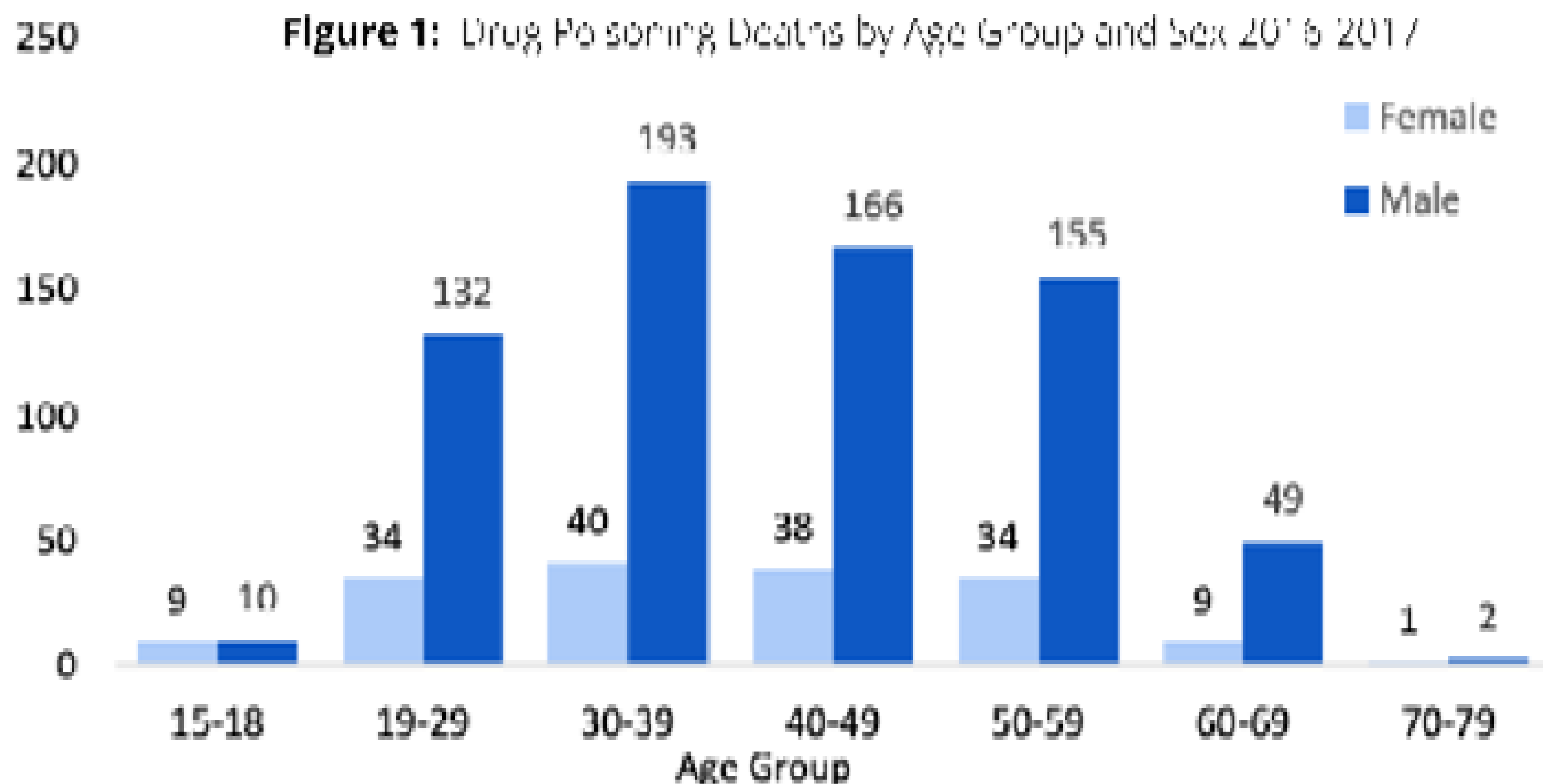
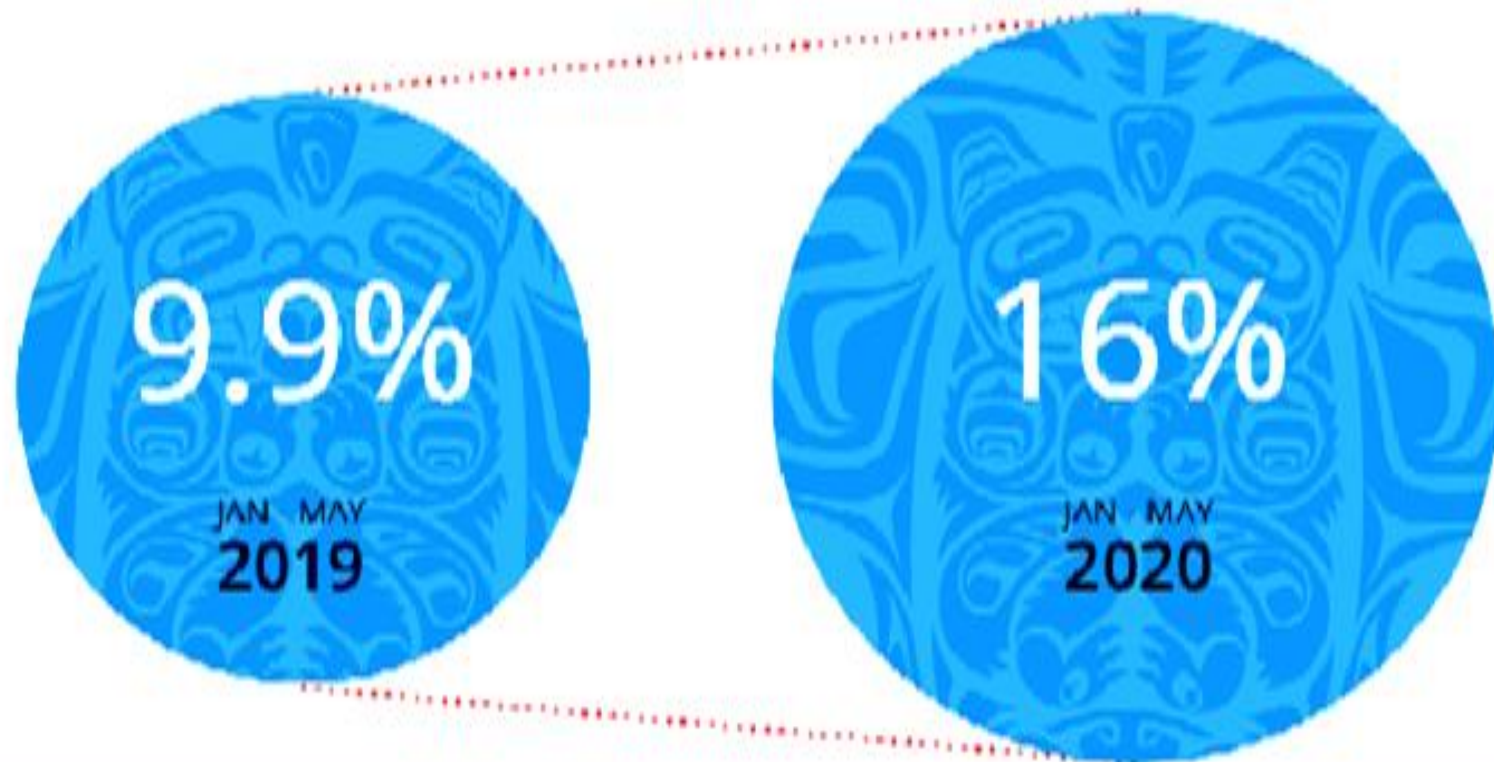


Figure 1: Drug Poisoning Deaths by Age Group and Sex 2016 2017

The crisis disproportionately impacts Indigenous People. 16% of drug poisoning deaths in BC between January and May 2020 were First Nations people. This number was 9% in 2019. Both numbers are significant, as First Nations represent 3.3% of the province's population.[14] (*See figure 2*)

Figure 2: First Nations Toxic Drug Deaths 2019 - 2020



Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in drug poisoning statistics. While the drug poisoning crisis at large in B.C. disproportionately affects men, First Nations women died from drug poisoning at 8.7 times the rate of other women in B.C.[13] *(See figure 3)*

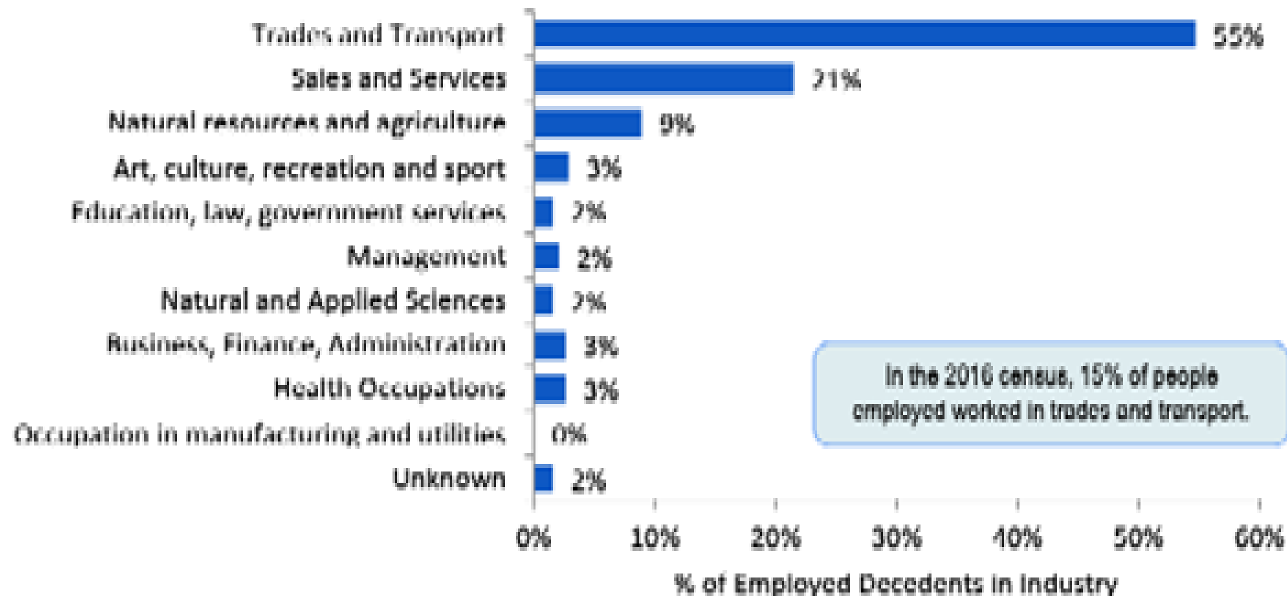
Figure 3: Drug Poisoning Rate for Indigenous Women 2019

8.7x

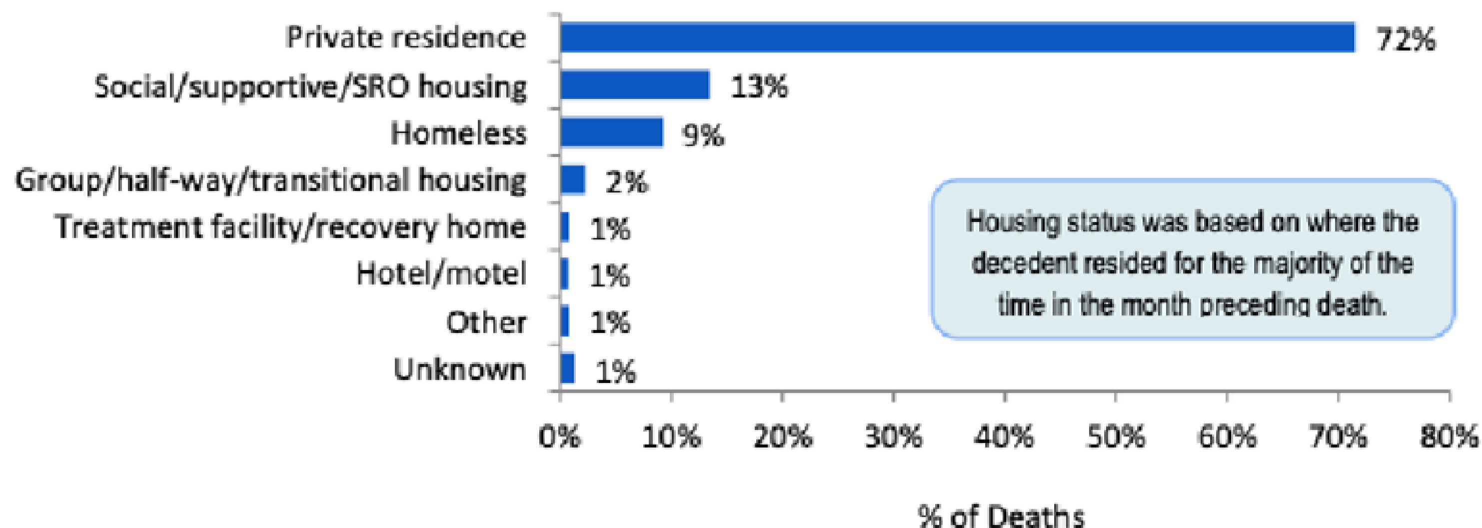
First Nations women died from overdose at 8.7 times the rate of other women in BC in 2019.

The crisis disproportionately impacts people who are unemployed, as well as people in the trades and transportation industries. A study of 872 drug poisoning deaths in BC from 2016 & 2017 shows that most people who took poisoned drugs were unemployed (51%). Of those employed, 55% were employed in the trades and transport industry.[14] *(See figure 4)*

Figure 4: Toxic Drug Deaths by Industry of Work 2016 - 2017



Most drug poisoning victims live in private residences. The above-mentioned study from 2016 & 2017 shows 72% of drug poisoning death victims as having lived (and died from drug poisoning) in private residences, thirteen percent as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.[14] *(See figure 6)*



The crisis disproportionately impacts people who are grappling with pain and mental health issues. The same study shows 79% of drug poisoning death victims had contact with health services in the year preceding death (690/872). Over half (56%) had contact for pain-related issues (389/690). More than half of the cohort (455/872) (52%) were reported to have had a clinical diagnosis or anecdotal evidence of a mental health disorder.[14] (*See figure* 5)

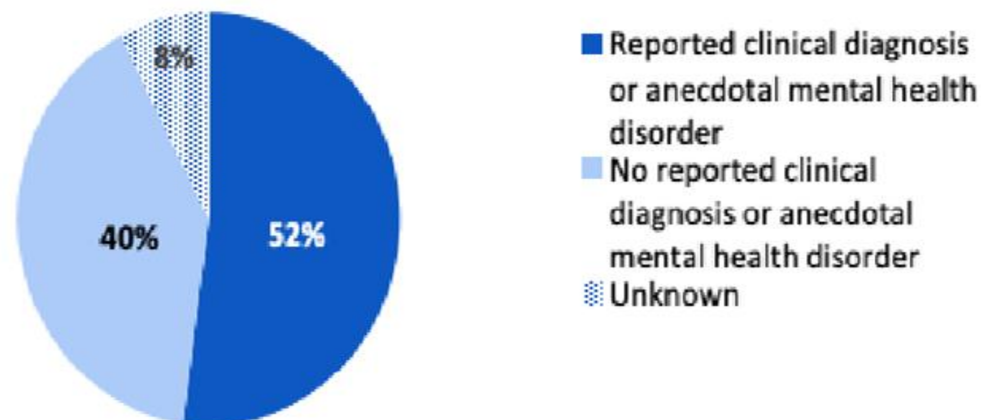
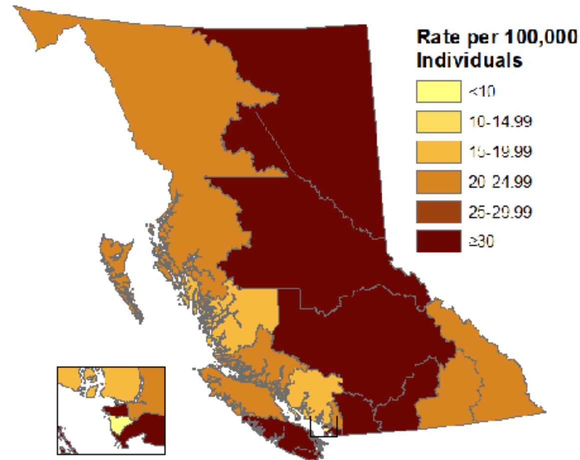


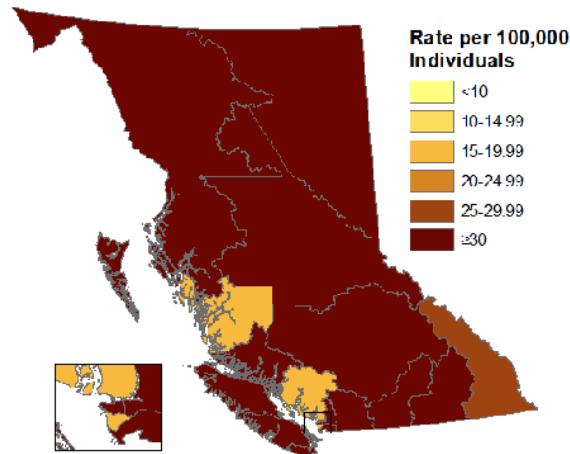
Figure 5: Drug Poisoning Deaths and Reported Mental Health Disorders 2016 - 2017

Figure 9: Illicit Drug Toxicity Death Rate Maps by Health Services Delivery Area

2020 Illicit Drug Toxicity Death Rates by
Health Services Delivery Area



2021 Illicit Drug Toxicity Death Rates by
Health Services Delivery Area



References for health regions can be found at: http://www2.gov.bc.ca/gov/content/data/geographic-data-services/land-use/administrative-boundaries/health-boundaries

WALK WITH ME

UNCOVERING THE HUMAN DIMENSIONS OF THE DRUG POISONING CRISIS IN SMALL B.C. COMMUNITIES

POLICY REPORT - COMOX VALLEY

Sharon Karsten, PhD.

2021

Photo by: Tracy Glover

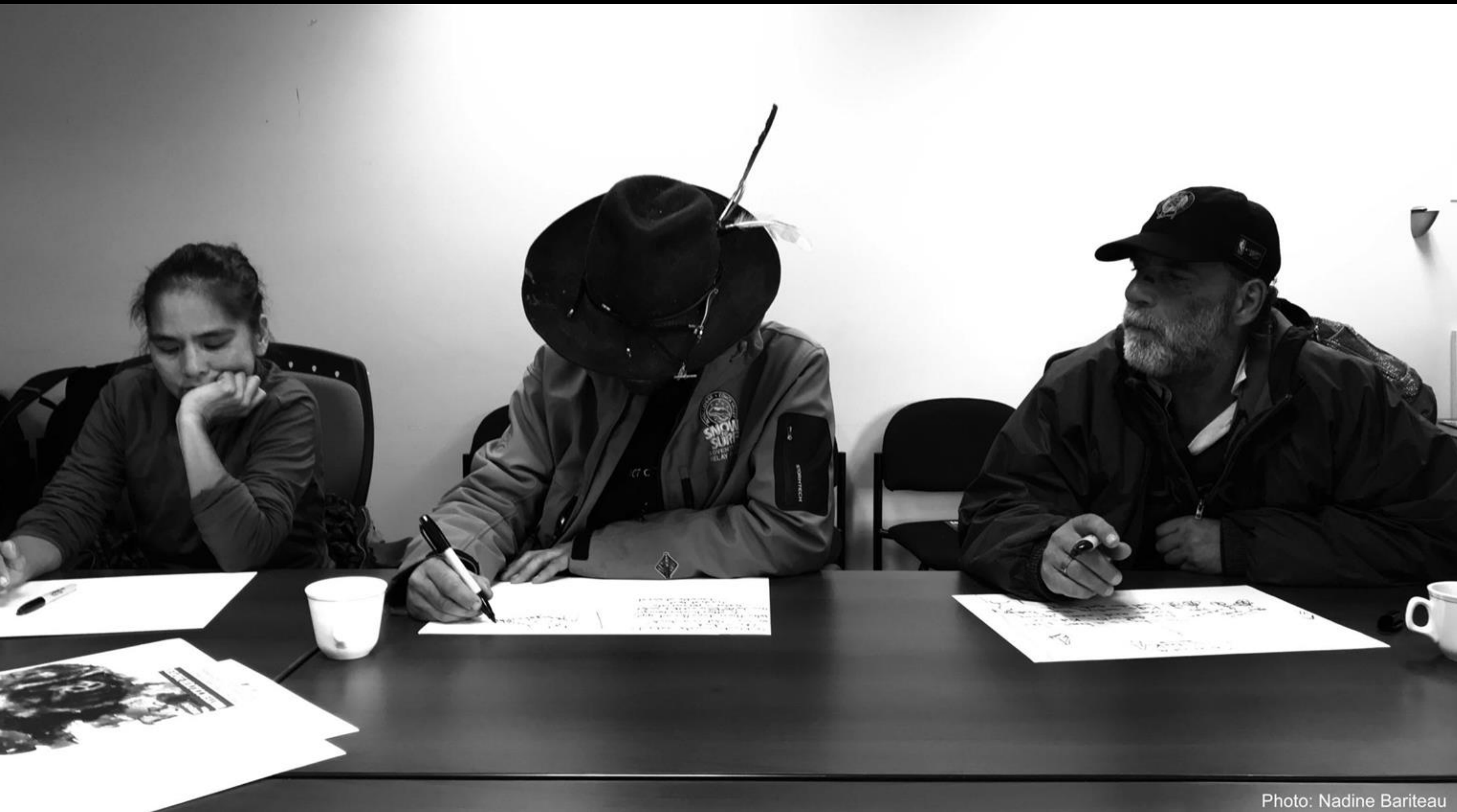


Photo: Nadine Bariteau

uncovering the human dimensions of the overdose
30 September – 21 November 2020 / Wednesdays + Saturdays / 10

COMOX VALLEY ART
public place: sacred space

PERS
UG MART
FOR LEASE

Photo: Kyle Little

Photo: Nadine Bariteau

WALK WITH ME
uncovering the human dimensions of the
November 2020 / Wednesdays + Saturdays
CVAG
CVAG

I think, first and foremost, we need to get this dehumanization thing completely eradicated.

We need the people who are comfortable, with money and a place to live and all the modern trappings of life, to realize that they are just systematically taking the easy way out. And they're not viewing people as people anymore, the people on the streets, because then they can treat them like the trash that they feel, you know, is that the people strew about.

(E. Mayoh, personal communication, October 11, 2019)

Photo by: Nadine Boriteau

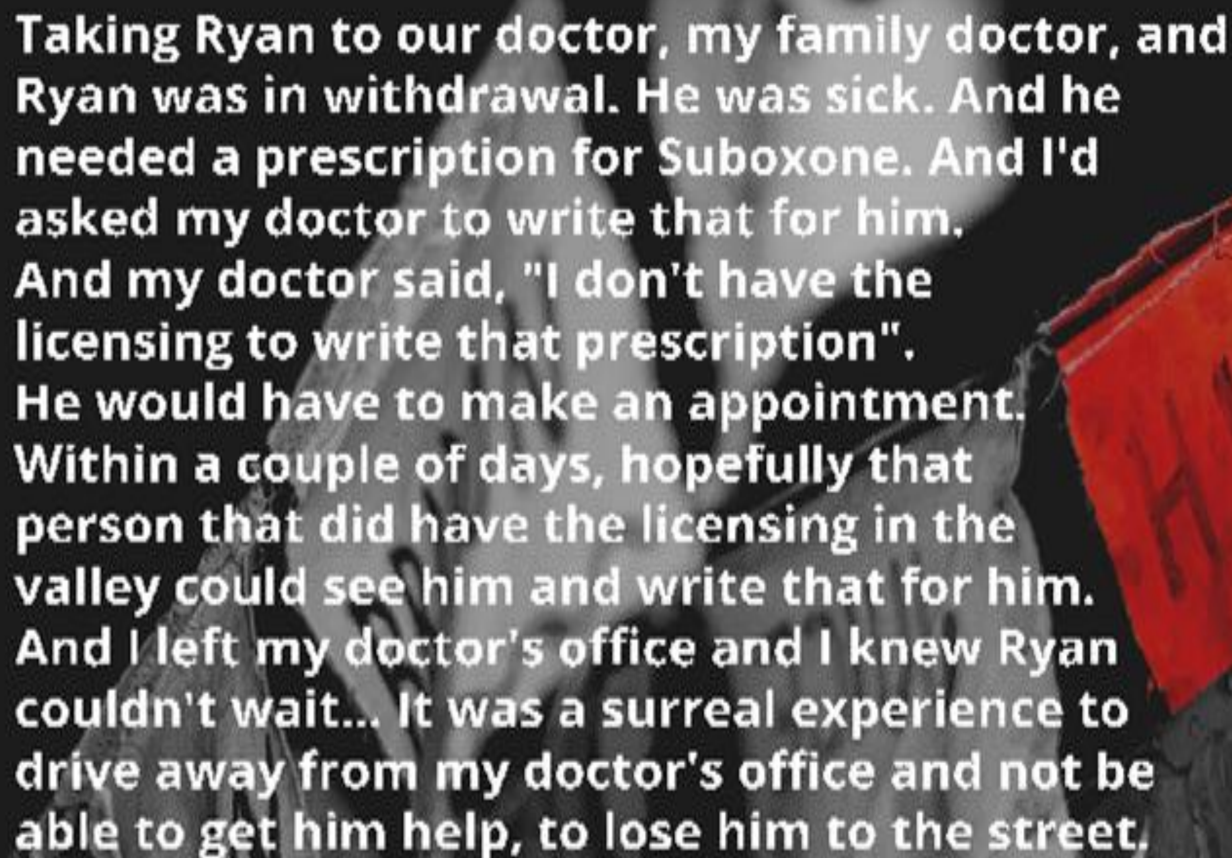


Photo by: Kyle Little

RECOMMENDATIONS

1. Advocate the Federal Government for decriminalization of simple possession

5. Reduce/Eliminate stigma and racism within the community at-large

9. Create a PWLLE Leadership Group

10. Pursue ongoing improvements in housing, mental health, education

11. Conduct Gaps and Opportunities Analysis

12. Invest in PWLLE as Change Leaders

"Breaking Trail" depicts the hike
Outback of Mt.Washington, a
destination on Vancouver
Recreation
LTD

WALK WITH ME

UNCOVERING THE HUMAN DIMENSIONS OF THE DRUG POISONING CRISIS IN SMALL B.C. COMMUNITIES

POLICY REPORT - COMOX VALLEY

Sharon Karsten, PhD.

2021

Photo by: Tracy Glover

With Gratitude to our Partners:

And Funders:

'Walk With Me' Team - Comox Valley

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Report Design:
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www.walkwithme.ca

LAND AKNOWLEDGEMENT

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

We acknowledge, as well, the teachings we have received from K'ómoks Elder and Traditional Knowledge Keeper Barb Whyte, descendent of the Pentlatch People, who has provided guidance at every step in the journey. Our hands are raised in gratitude.

ABSTRACT

Since labelled a provincial emergency in 2016, the toxic drug poisoning crisis in B.C. has claimed over 7,000 lives. Government, health and community service providers alike have struggled to find solutions to the crisis, developing numerous interventions aimed to reduce deaths, harm and stigma. Despite these efforts, toxic drug poisoning deaths have continued to climb, with 2020 enacting the most fatalities ever. 'Walk With Me' is a research and community action project, developed in the Comox Valley and Kamloops, B.C. as a partnership between Comox Valley Art Gallery, Thompson Rivers University and AVI Health & Community Services, that aims to develop humanistic, and systems-based solutions to this crisis. The project brings people impacted by the crisis together for story- and insight-sharing, and disseminates key findings outward – to policy-makers, systems leaders and community members at-large. The project foregrounds the wisdom of people experiencing the crisis (people with lived experience, their family members and front-line workers). In centering lived experience, the project illuminates ways forward for community and systems transformation.

ETHICS STATEMENT

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, human research ethics approval from Thompson Rivers University's Office of Research Ethics

Keywords

toxic drug poisoning crisis
systems change
stigma reduction
policy
community action

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 Brooke Mills, Evan Mayoh, and Myles - 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 think about you often – especially when we walk.

TABLE OF CONTENTS

Land Acknowledgement ii
Abstract iii
Ethics Statement iv
Dedication v
Table of Contents vi
List of Key Terms ix
Statistics x
Chapter 1. About 'Walk With Me' 1
1.1. Why examine the crisis in small communities? 1
1.2. Why Use Cultural Mapping as a core methodology? 2
1.3. What role does art play? 2
1.4. How is the project structured? 3
1.5. What are the project's objectives? 3
1.6. How has the Comox Valley Project Unfolded? 4
1.7. How has the Comox Valley Community Engaged in Walk With Me? 4
1.8. How has this report been developed and structured? 5
1.9. Summary 5
Chapter 2. Toxic Drug Poisoning Crisis - Context 6
2.1. History 6
2.2. Impact 7
2.2.1. Who is Most Impacted by this Crisis? (Demographics/ Characteristics) 7
2.2.2. Where is this crisis unfolding? (Rural vs Urban Drug Poisoning Rates) 12
2.2.3. How is the drug poisoning crisis unfolding in Vancouver Island Health Authority, and in the North Island Service Delivery Area? 13
2.2.4. How is the Crisis unfolding in the Comox Valley? 14
2.3. What are Key Contributing Factors? 15
2.3.1. Increase in Toxic Supply / Provision of Safe Supply 15
2.3.2. Safe Supply 16
2.3.3. Opioid Agonist Therapy 17
2.3.4. Over-Prescription of Opioid-based Pain Medication 19
2.3.5. Criminalization 20
2.3.6. Failure to Decriminalize 24
2.4. Upstream Services - Social Determinants of Health 26
2.4.1. Housing 27
2.4.2. Mental health services 28

TABLE OF CONTENTS

2.4.3. Education 28
2.4.4. Hyper-capitalism and 'Poverty of the Spirit' 29
2.5. Summary 31
Chapter 3. Findings 33
3.1. Lived Experience of the Crisis 33
3.1.1. Fentanyl and drug mixing: 'A different ballgame" 34
3.1.2. The experience of drug poisoning 36
3.1.3. The Medical System's Role 37
3.1.4. Stigma 38
3.1.5. Stigma in Health Care 39
3.1.6. Stigma in Policing, Civic Services and the General Public 43
3.1.7. Racism 47
3.1.8. Loss of Trust – The Impact of Residential School & Inter-generational Trauma 48
3.1.9. Cultural Safety, Cultural Knowledge 50
3.1.10. Signs of Change 51
3.1.11. Summary 52
3.2. Decriminalization & Legalization 53
3.2.1. Summary 56
3.3. Safe Supply 56
3.3.1. Safe Supply - Barriers 57
3.3.2. Safe Supply Access 61
3.3.3. Summary 63
3.4. Community Services (Downstream) 63
3.4.1. Harm Reduction Services 64
Narcan 64
Drug poisoning Response Apps 65
Drug Testing 65
Harm Reduction Service Providers 67
Peer-Led Interventions 69
Fragility in Harm Reduction Services 70
Summary 71
3.4.2. Recovery Services & Supports 71
Detox 72

TABLE OF CONTENTS

Subsidiary Services 74
Coordination of Services 75
Community Integration 77
Summary 77
3.5. Social Determinants of Health (Upstream) 78
3.5.1. Housing 78
3.5.2. Mental Health 80
3.5.3. Education 82
3.5.4. Summary 83
Chapter 4. Recommendations **87**
Recommendation #1 - Advocate the Federal Government for decriminalization of simple possession 88
Recommendation #2 - Re-commit to the operationalization of safe supply 89
Recommendation #3 – Invest in full-spectrum drug testing 90
Recommendation #4: Reduce/eliminate stigma and racism within the health and criminal justice systems 91
Recommendation #5: Reduce/Eliminate stigma and racism within the community at-large 93
Recommendation #6: Increase the accessibility and connectivity of OPS Services 94
Recommendation #7: Increase the accessibility and connectivity of Recovery Services 95
Recommendation #8: Develop a 'Hub' 96
Recommendation #9: Create a PWLLE Leadership Group 97
Recommendation #10: Pursue ongoing improvements in housing, mental health, education 98
Recommendation #11: Conduct Gaps and Opportunities Analysis 99
Recommendation #12: Invest in PWLLE as Change Leaders 100
4.1. Summary 100
Chapter 5. Conclusion **101**

LIST OF KEY TERMS

Term	Definition
AVI	AVI Health and Community Services – Harm Reduction Agency
Carfentanil	Synthetic opiate
Fentanyl	Synthetic opiate
PWLLE	People with lived/living experience of drug use
Naloxone	Medication used to counter effects of toxic drug poisoning
OAT	Opioid Agonist Therapy: treatment for addiction to opioids such as heroin, oxycodone, hydromorphone, fentanyl, and percocet. The therapy involves taking opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioids.
OPS	Overdose Prevention Site: designated sites where drug consumption is witnessed, leading to immediate response in the event of a toxic drug poisoning.
Stimulant	Drugs that tend to temporarily increase energy (rather than relax, as is often the case with heroin and other opioids), including cocaine and methamphetamines.
TRU	Thompson Rivers University
Unbroken Chain	Indigenous Harm Reduction Program through Indigenous Women's Sharing Society
VIHA	Vancouver Island Health Authority
W-18	Illegal synthetic opioid more potent than fentanyl.

17,602

Number of apparent opioid toxicity deaths in Canada between January 2016 and June 2020. [1]

6,743

Number of illicit toxicity drug deaths in BC between January, 2016 and November, 2020. [2]

86.8%

Percentage of Illicit Drug Toxicity Deaths, 2017 – 2020, in which illicit fentanyl and analogues were identified as relevant to death. [3]

1 ABOUT 'WALK WITH ME'

'Walk With Me' has been developed in response to a crisis that has blindsided municipal governments and communities, large and small, across the country. The crisis has had a heavy impact in BC. Since it was labeled a provincial emergency in 2016, illicit drug toxicity deaths have totalled over 7,000. For governments, communities, front-line workers, families and people with lived and living experience, the crisis can feel insurmountable. This project, developed by research and community teams in Kamloops, Comox Valley and Campbell River, B.C., brings together diverse stakeholders to re-frame the crisis through a process of cultural mapping, and to imagine new ways forward.

The project asks, as its central research question: **How can community-based cultural mapping surrounding the toxic drug poisoning crisis help reduce deaths, stigma and harm, improve social cohesion and create systems change for populations facing the crisis first-hand in small and rural communities?** We wanted to understand how this crisis was playing out uniquely in B.C.'s small communities, and shine light on the stories of human loss, crisis and resilience emerging through it. By bearing witness to these and asking others to do the same, and by putting forward policy recommendations emerging from those at the heart of the crisis, we aim to create the conditions for lasting change.

1.1. Why examine the crisis in small communities?

Despite their differences in history, economic stability, social networks, etc., small communities share a common challenge in addressing the health and social welfare needs of their most vulnerable citizens. Such communities 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 communities, physically removed from services which are often centralized in downtown cores – leading to challenges for service providers to reach people in ways that are nimble and strategic.

Frequently, small communities are also lacking key elements within a 'spectra' of care. When crises arise, for instance as related to pandemics, forest fires, floods, etc. the resident vulnerable population becomes further affected, displaced and dispersed – leading to even more profound issues of care.

1.2. Why use Cultural Mapping as a core methodology?

Cultural mapping, a community-engaged research methodology, can help small communities make visible the lived and living experience of people facing crises first-hand – and can chart needed connectivity between people with lived/living experience (PWLLE), family members and frontline social service providers; and between these groups and police, government, policy-makers and the broader public. Throughout the last 30 years, the phenomenon of cultural mapping has gained international currency as an instrument of collective knowledge building, communal expression, empowerment and community identity formation. Through cultural mapping, verbal story and insight sharing is combined with artistic sharing to foster understanding about lived realities. Our main mode of mapping in this project occurs through a draw-talk protocol, wherein participants draw about their lived experience, and speak to their drawings, engaging with the researchers in semi-structured interviews. This methodology is adaptive, and foregrounds the communication preferences of participants, who have at-times used other mediums than drawing, including music and photography, or story sharing on its own, to communicate elements of their lived experience.

1.3. What role does art play?

Arts-based investigative frameworks have, in recent years, been readily embraced by health researchers, especially those looking at the social determinants of health by using techniques such as photovoice. Yet in spite of these developments, arts-based, humanities-oriented research approaches addressing multifaceted issues like the toxic drug poisoning crisis remain rare. Some excellent work on 'journey mapping' of the crisis has produced powerful initial results and provides a kind of proof of concept for our work.[4] But where such approaches also solicit community input, they tend not to emphasize individual voices and experiences. Instead of foregrounding unique stories and maps from locals, such mapping has consolidated viewpoints and employed a single graphic facilitator, reflecting the work of skilled note-takers and artists visually representing the broad strokes of oral exchanges, typically in workshop and seminar settings. What tends to get lost are the individual voices, the individual

records and layers - the mappings - of lived experience. The act of bringing PWLLE and their representations of experience into a community-wide dialogue enables, we believe, a powerful evolution of our communities' potential to develop meaningful solutions to the crisis.

1.4. How is the project structured?

This project has been developed by Dr. Will Garrett-Petts, Principal Investigator (AVP Research, Thompson Rivers University), and Dr. Sharon Karsten (Research Director, Comox Valley Art Gallery), Co-Investigator. Thompson Rivers University (TRU) serves as the managing partner, and the Comox Valley Art Gallery (CVAG) as community partner, along with AVI Health and Community Services.

At the core of the project is an Advisory Team that includes participants from Comox Valley, Campbell River and Kamloops, B.C. This group, consisting of municipal managers, health/service providers and PWLLE, have worked with Garrett-Petts and Karsten to develop this project, in parallel, within these small communities. While each community adapts the project in response to its own unique needs and opportunities, the three communities together, through this research team, benefit from cross-community analysis, sharing and learning. Insights from each localized project are shared through the research team, leading to dynamic, cross-community sharing, and collaborative growth.

We gratefully acknowledge the funding received from: Island Health, BC Arts Council, SPARC BC and Vancouver Foundation.

1.5. What are the project's objectives?

To enable new ways of thinking about the toxic drug poisoning crisis as it is played out within these communities, and within small B.C. cities generally – leading to systemic forms of change.

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.

To develop insights surrounding the crisis leading to the design of progressive change and transformation.

To create innovative arts-based research models pertaining to the crisis that are participatory—produced through multi-level community agency.

1.6. How has the Comox Valley Project Unfolded?

The Comox Valley project has been in 'active research' mode since 2019, when Karsten began hosting research sessions with PWLLE, their family members, and front-line workers. Alongside a staff team that includes K'ómoks Elder and Traditional Knowledge Keeper Barb Whyte, Outreach Workers (and AVI Health and Community Services Staff) Galen Rigter, Sarah Gifford, Holly Taylor and Sarah Delaney-Spindler, Outreach Worker (and coordinator of Unbroken Chain Indigenous Harm Reduction program) Patti Alvarado, Artist and Creative Director Nadine Bariteau and PWLLE Sam Franey (Community Engagement Director) and Sophia Katsanikakis (Communications Coordinator). Karsten began meeting regularly with groups of PWLLE – hosting research sessions at the Comox Valley Art Gallery. Each session was hosted with food, and involved an ethics presentation (and the completion of consent protocols); participants were invited to draw and/or speak to the lived experience of the crisis, responding to the core research question: How has the toxic drug poisoning crisis impacted you and your community? Participants engaged in dialogue with the research team, and were asked to elaborate on parts of their drawings, stories or insights. The Research Team held these sessions with commitment to respect for those at the heart of this crisis, through trauma-informed practice, and with cultural safety protocols.

The audio interviews were recorded, transcribed, and coded using NVIVO data analysis platform. They were also converted into a series of 'audio walks' – experiential audio journeys that formed the basis of community engagement events and sharing circles, and informed the final report.

1.7. How has the Comox Valley Community Engaged in Walk With Me?

Between September and December, 2020, the Research Team hosted community engagement forums in the Comox Valley Art Gallery's main gallery space, and outside on its Plaza. Attendees were invited to view the art produced in the project within the Gallery space, and engage in guided audio walks. These walks led groups of up to 25 participants on 40-minute walking journeys that left from, and returned to, the Gallery's Outdoor Plaza. Participants walked through parks, under bridges, and through alleyways, while listening to the audio stories and insights gifted to the project by PWLLE, family members and front-line workers. Upon returning to the Gallery, participants were provided with food, and hosted in a Sharing Circle hosted by Elder/Traditional Knowledge Keeper Barb Whyte and the research team.

Outreach support and community resources were made available throughout the entirety of the project. Throughout this period, the Walk With Me team hosted over 32 Sharing Circles with members of the public, engaging with over 500 participants – including local government, community, and health authority stakeholders, as well as PWLLE and members of the general public.

1.8. How has this report been developed and structured?

This report, titled the 'Walk With Me: COMOX VALLEY – POLICY REPORT', draws upon the insights emerging from the research accomplished in the Comox Valley project – with PWLLE, family members and front-line workers. The report includes, in addition to this Introduction (Chapter 1: About Walk With Me), a Literature Review (Chapter 2: The Toxic Drug Poisoning Crisis - Context), Findings (Chapter 3), Recommendations (Chapter 4) and Conclusion (Chapter 5). Together, these offer a snapshot of the crisis' impact in the Comox Valley, and shine light on potential pathways forward in reducing deaths, stigma and harm, improving social cohesion and creating systems change in support of people at the heart of the crisis.

1.9. Summary

The 'Walk With Me' project is a multi-sectoral, community-engaged research project, designed to create systems change in small B.C. communities, as related to the toxic drug poisoning crisis. The 'Walk With Me' team invites readers to receive this report with an open mind and open heart – and to work together towards the catalyzation of long-term, meaningful change.

2 TOXIC DRUG POISONING CRISIS - CONTEXT

2.1. History

In April of 2016, the province's Health Officer, responding to rising numbers of drug poisoning deaths within British Columbia, declared a public health emergency under the Public Health Act – a designation that has continued into the present.[5] In comparison with other provinces, BC has consistently, in recent years, shown the highest per-capita rates of apparent illicit drug toxicity deaths[a].[1,6,7,8,9,10] Between 2016 and 2020, over 6,500 people died in BC as a result of the drug poisoning crisis; drug poisoning deaths for this period were higher than unnatural deaths from other common causes, including suicide, motor vehicle incident and homicide[b].[2] Between April and November, 2020, the number of deaths in BC resulting from drug poisoning (1,279) was almost triple the number of deaths resulting from COVID-19 (432).[11] The Province's move to label the drug poisoning crisis a provincial emergency was a first in BC and Canada, and triggered a multi-faceted intervention aimed to save lives and reduce harm for people who use drugs.[5]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 drug poisonings, passage of legislative changes, increased toxicological testing of drugs, expansion of harm reduction services (ie: the establishment of drug poisoning prevention services and expansion of supervised consumption sites), the development of a ministry focused on mental health and addictions, etc.[5]
These interventions are claimed by the Province "to have averted 60

[a] Figures from 2017-2020 show BC as having the highest per-capita drug poisoning rate. It is worth noting that drug poisoning reporting in BC up until 2017 included only deaths due to opioid drug poisoning, and in 2018 the reporting was altered to include drug poisonings due to all illicit substances. This differs from most provinces, which continued to calculate only opioid-related deaths (except for Quebec who undertook this same reporting shift in 2018). Even before this shift was made, BC's per-capita drug poisoning numbers were remarkably high in comparison to other provinces.

[b] Comparative data not yet available for 2020

percent of all possible drug poisoning deaths since the declaration of the public health emergency".[5] And yet, while these have purportedly helped mitigate the death toll, drug poisoning deaths have continued to rise.

An exception to this trend occurred in 2019, as the province's illicit drug toxicity death number fell for the first time since 2012.[3] Attributable, perhaps, to these multiple interventions, the 2019 death toll in B.C. showed a 36% reduction in comparison to the previous year - with total illicit toxicity deaths falling to 984 (2019) from 1,549 (2018).[12] Yet the onslaught of the COVID-19 pandemic appears to have counteracted this reversal, with drug poisoning levels having more than doubled in April through November, 2020, in comparison to the same timespan in 2019.[12] Indeed, the 2020 total for provincial illicit toxicity deaths has exceeded the total in any prior year, with the pandemic being identified by numerous experts, including BC's chief coroner Lisa Lapointe, as having significantly exacerbated the crisis.[11]

2.2. Impact

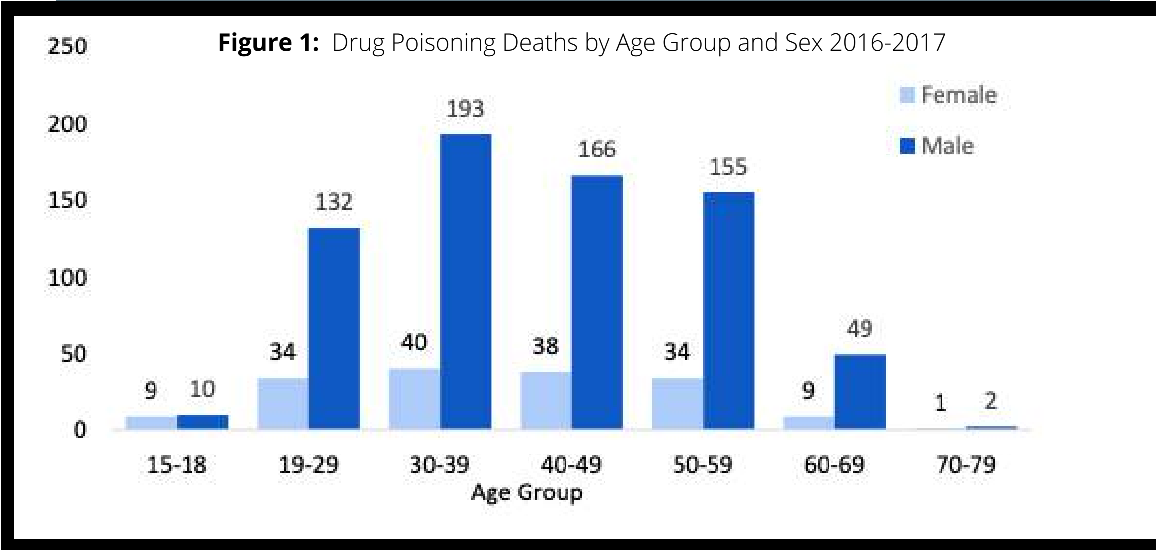
What we know about the way in which this crisis is unfolding provincially and locally is both informed and limited by the data collected by the Province, Vancouver Island Health Authority, First Nations Health Authority, the BC Coroners Service, BC Centre for Disease Control and other health, government and community service agencies. In what follows, we walk through some of the key statistics that have emerged since the crisis was labeled a provincial emergency, with emphasis placed on the most recent numbers.

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

The question of 'who is most impacted?' is significant, as the response holds the potential to inform our understanding of the crisis, shape public policy and systems change strategies, and inform community action. The following section highlights key demographic-based statistics that have emerged since the onslaught of the crisis in 2016.

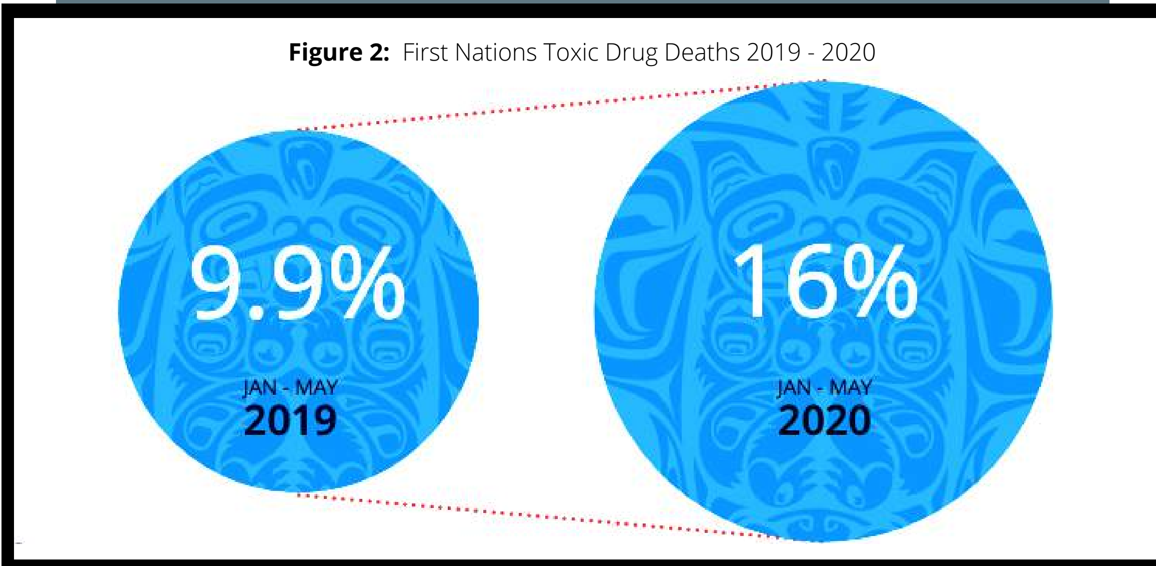
The crisis disproportionately impacts middle-aged men. In 2021 (up to January 31), 70% of those dying of drug poisoning in BC were between ages 30 and 59. Males accounted for 83% of deaths. Similar figures are reported for 2016 - 2020. [14] *(See figure 1)*

Figure 1: Drug Poisoning Deaths by Age Group and Sex 2016-2017



The crisis disproportionately impacts Indigenous People. 16% of drug poisoning deaths in BC between January and May 2020 were First Nations people. This number was 9% in 2019. Both numbers are significant, as First Nations represent 3.3% of the province's population.[14] *(See figure 2)*

Figure 2: First Nations Toxic Drug Deaths 2019 - 2020



Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in drug poisoning statistics. While the drug poisoning crisis at-large in B.C. disproportionately affects men, First Nations women died from drug poisoning at 8.7 times the rate of other women in B.C.[13] *(See figure 3)*

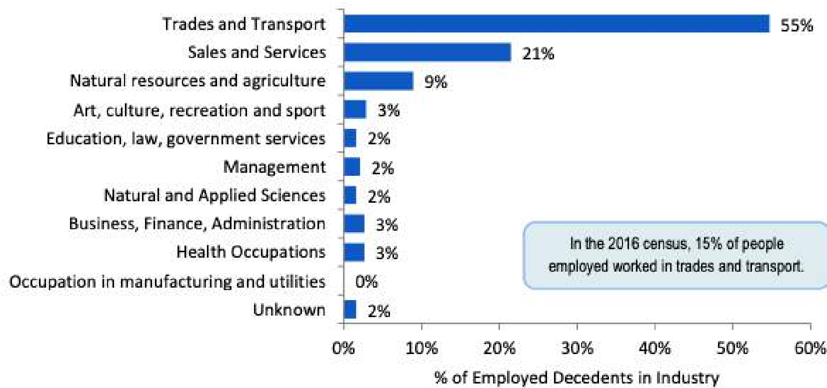
Figure 3: Drug Poisoning Rate for Indigenous Women 2019

8.7x

First Nations women died from overdose at 8.7 times the rate of other women in BC in 2019.

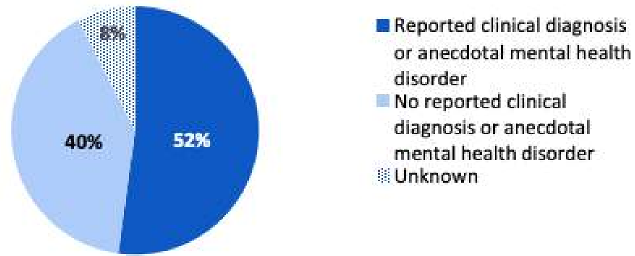
The crisis disproportionately impacts people who are unemployed, as well as people in the trades and transportation industries. A study of 872 drug poisoning deaths in BC from 2016 & 2017 shows that most people who took poisoned drugs were unemployed (51%). Of those employed, 55% were employed in the trades and transport industry.[14] *(See figure 4)*

Figure 4: Toxic Drug Deaths by Industry of Work 2016 - 2017



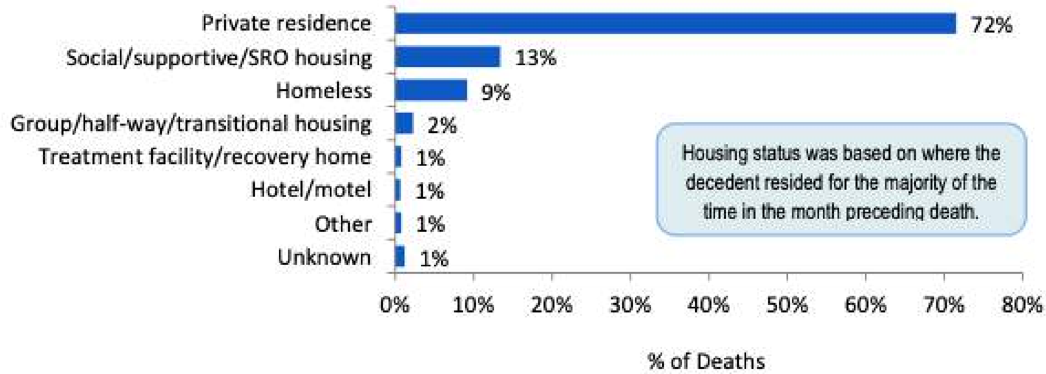
The crisis disproportionately impacts people who are grappling with pain and mental health issues. The same study shows 79% of drug poisoning death victims had contact with health services in the year preceding death (690/872). Over half (56%) had contact for pain-related issues (389/690). More than half of the cohort (455/872) (52%) were reported to have had a clinical diagnosis or anecdotal evidence of a mental health disorder.[14] (*See figure 5)*

Figure 5: Drug Poisoning Deaths and Reported Mental Health Disorders 2016 - 2017



Most drug poisoning victims live in private residences. The above-mentioned study from 2016 & 2017 shows 72% of drug poisoning death victims as having lived (and died from drug poisoning) in private residences, thirteen percent as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.[14] *(See figure 6)*

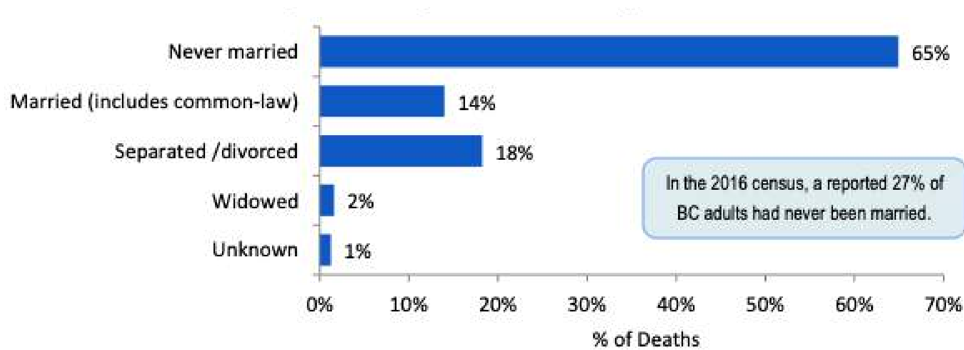
Figure 6: Drug Poisoning Deaths by Decedent Housing



Note: SRO housing = single room occupancy housing

Most drug poisoning victims are not married. Sixty-Five percent of drug poisoning victims in the study had never been married.[14] *(See figure 7)*

Figure 7: Drug Poisoning Deaths by Marital Status 2016 - 2017



Most drug poisoning victims use drugs alone, rather than with other people. The majority of drug poisoning victims (69%) had used their drugs alone.[14]

Drug poisonings increase during income assistance payment week. A British Columbia Coroners Service Report analyzing data in 2019 & 2020 shows the daily average of drug poisoning deaths in the province as having risen from 4.2 to 5.4 in the four days following income assistance payment day (Weds – Sun).[14]

These statistics help form a demographic profile of drug poisoning crisis victims that, though limited in scope, nonetheless helps to inform understanding. From them, we understand this crisis as most severely impacting middle-aged men and Indigenous peoples, notably Indigenous women. We also see the crisis' inordinate impact on those with pain management and mental health issues. And we observe an inverse correlation between drug poisoning rates and income, recognizing a higher rate of drug poisoning amongst those who are unemployed, and accessing income assistance.

While presenting a demographic profile of those most impacted by the crisis, it is important to note that these statistics do not adequately portray the full picture. We know that people from all walks of life have been impacted by this crisis – including people from high- and middle-income backgrounds, women, people in a wide range of professions including doctors, police officers, etc. Recognizing this fact, it is requested that readers receive these statistics with awareness that they tell a part of, rather than the full, story.

2.2.2. Where is this crisis unfolding? (Rural vs Urban drug poisoning Rates)

The question 'where is this crisis unfolding?' is important, as it informs our understanding of it's 'on the ground' impact.

While many see the drug poisoning crisis as predominantly confined to large urban centres, this is not, in fact, the case. Opioid use and drug poisoning rates in small cities and towns is growing, and in some cases surpassing 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".[15] 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 paramedics attended drug poisoning events".[16]And a recent study by BC Emergency Health Services shows that although urban centres in BC witnessed the deadliest effects of the crisis in 2020, rural and remote areas also witnessed significant spikes in drug poisoning calls to 911. Some of the highest increases in drug poisoning calls, it should be noted, were found on the BC coast and in small cities on Vancouver Island.[17,18] These statistics challenge a common view that the drug poisoning crisis is most significantly impacting large urban centres.

2.2.3. How is the drug poisoning crisis unfolding in Vancouver Island Health Authority, and in the North Island Service Delivery Area?

Between 2016 (the year in which the drug poisoning crisis was designated a provincial health emergency) and 2020, Island Health recorded 1,078 illicit toxicity deaths.[2] This figure represents the third-highest death rate recorded amongst BC's Health Authorities, following behind Fraser Health Authority (2,247) and Vancouver Coastal Health Authority (1,934), and leading (narrowly) Interior Health (1,071) and Northern Health Authority (415).[2] Island Health is divided into three distinct Health Service Delivery Areas (HSDA), including South Vancouver Island (including Greater Victoria, the Saanich Peninsula and the Southern Gulf Islands), Central Vancouver Island (including Greater Nanaimo, Cowichan Valley, Oceanside and Alberni/Clayoquot) and North Vancouver Island (Including Comox Valley, Greater Campbell River and Vancouver Island North and West) (Island Health, n.d). Again drawing on stats from 2016 through 2020, we see that the majority of drug poisoning deaths have occurred in South Vancouver Island HSDA (515) , followed by the Central Vancouver Island HSDA (404), and North Vancouver Island HSDA (154).[2, 19, 20]

When examining drug toxicity deaths as occurring at a rate (per 100,000 people), we see the highest illicit drug toxicity death rates, between 2016 and 2020 as occurring within Central Vancouver Island (27.4), followed by South Vancouver Island (24.6), and North Vancouver Island (23.5)[c].[2] In this snapshot, Central Vancouver Island is seen as the HSDA most affected by the crisis – with South Vancouver Island and North Vancouver Island rates closely aligned.

This data is significant, as it shows the impact of the crisis as higher in the small cities of Nanaimo and Duncan and their surrounding areas, than in the large city of Victoria and its surrounding areas. It also shows the area occupied by the smaller cities of the Comox Valley and Campbell River as witnessing drug poisoning rates similar to the area occupied by Victoria and area. While North Vancouver Island HSDA can be seen to have escaped the worst of the crisis, between 2016 and 2021, as measured in both numbers and rates of illicit toxicity deaths, it has nonetheless suffered a substantial blow.[2] Furthermore, Illicit Toxicity Death Rates for Island Health at-large increased between January and May, 2021.[21] North Vancouver Island, as well as the other Service Areas, are now classified in the highest 'rate' category, suffering more than 30 deaths per 100,000 people.[21]

[c] *Numbers average of Drug Toxicity Death Rates by Health Services Delivery Area from 2016-2020. P.17.*

2.2.4. How is the Crisis unfolding in the Comox Valley?

Within North Vancouver Island HSDA, drug poisonings are concentrated in the Comox Valley Local Health Area (Comox Valley), and Greater Campbell River Local Health Area (Campbell River). Of the 154 illicit drug toxicity deaths that occurred in the North Island HSDA between 2016 and 2020, 68 occurred within the Comox Valley, and 77 in Campbell River. In 2020, 13 illicit drug toxicity deaths occurred within Comox Valley, and 15 in Campbell River. In terms of number of deaths, we see the two communities, Comox Valley and Campbell River, as having similar numbers of drug poisoning, with Campbell river leading slightly. These numbers have remained relatively consistent in both areas over the 2016-2020 time period.

When examined in rates versus numbers, the rate (per 100,000 people) of drug poisoning deaths in Comox Valley between the years 2016 and 2020 (18.8) is significantly lower than that in Campbell River for the same time period (33.2). The fact that Campbell River has a lower population than the Comox Valley reveals a significant difference between the communities in their per-capita drug poisoning rates. From this vantage-point, Campbell River can be seen, between the years 2016 – 2020, to have been more severely impacted by the crisis than the Comox Valley. (Island Health, personal communication, March 12, 2021).

However, while Campbell River has shown higher numbers and rates of drug poisoning between 2016 and 2020, a recent shift is observed. In 2020, paramedic attended illegal drug poisoning events in the Comox Valley rose by 50% to 173, exceeding Campbell River's 162.20 Furthermore, in the first five months of 2021 (January – May), the City of Courtenay witnessed the same number of drug poisonings as it had through the entirety of the previous year (2020) – 12, versus Campbell River's 7.9 This trend shows the Comox Valley, and Courtenay in particular, as having recently surpassed Campbell River as a site for toxic drug poisoning numbers.

We also know from data provided by Island Health that a higher percentage of drug poisonings in the Comox Valley, between 2016 and 2020 have happened in private residences (74% versus 62% in Campbell River, and 61% in Island Health at-large). It is difficult to know the reason for this difference… it might signify a stronger culture of shame and 'closed door' use of drugs in the Comox Valley versus Campbell River; it could also represent a stronger culture of use amongst people who reside in homes versus, for instance, those living unhoused (Island Health, personal communication, March 12, 2021).

Such analysis should recognize the dangers of conceiving of drug poisoning rates 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 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.

2.3. What are Key Contributing Factors?

The drug poisoning crisis, it should be said, has been precipitated by a 'perfect storm' that includes an increase in toxic supply of drugs, over-prescription of opioid-based pain medication, 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, erosion of mental health supports and erosion of education supports, have been seen to have created a landscape in which the drug poisoning crisis was fostered and enabled. In what follows, we walk through this landscape, with an aim to sketch broadly the context in which this crisis was enabled to take hold.

2.3.1. Increase in Toxic Supply / Provision of Safe Supply

The rise of fentanyl as a dominant street drug has played a significant role in the rise in drug poisoning deaths. Fentanyl, a synthetic opioid that is roughly 100 times more potent than morphine and 50 times more potent than heroin, is legally used and distributed in pharmaceutical practice;[22] and is also made and distributed illegally, through various supply channels - notably through China, with significant levels of drug trafficking occurring online.[23] Drugs ordered online from outside the country are distributed, often, through decoy packages sent by mail or courier in small quantities to evade detection by Canada Border Services Agency[d].[24] Fentanyl traffickers range from organized crime operations to lone operators. Once the drug is in the country, it is diluted by clandestine labs, cut with fillers (such as powdered sugar,

[d] Canada's Border Services Agency currently requires a supplier's permission to open packages weighing less than 30 grams.

baby powder or antihistamines), and mixed with other drugs such as heroin, or packed into pills which are often made to look like OxyContin.[25] 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".[25]

Toxicity in the supply of fentanyl stems from its frequent manufacture in sub-standard labs, its mixture with other toxic substances, and its high level of potency. Drug Poisoning Alerts issued by Health Authorities have become common in B.C.[26] It is often the case that a 'bad batch' of fentanyl-containing drugs can be seen moving from large urban centres outward into neighbouring small centres and beyond.[27, 28] Over the past 9 years in BC, there has been a substantial increase in the proportion of apparent illicit drug toxicity deaths in which fentanyl has been detected. While this rate stood at 4% in 2012, by 2020 it had increased to a staggering 83%[e].[12] Post-mortem toxicology results released by BC Coroners Service (p.6) suggest that there has been a greater concentration of fentanyl in the illicit drug market between April and November, 2020, compared with previous months in 2020. From April to November, 2020, approximately 13% of cases had extreme fentanyl concentrations as compared to 8% from Jan 2020 to Mar 2020". The closure of borders brought about by the onslaught of COVID-19 pandemic has complicated these drug supply chains, and is seen widely to have resulted in increased toxicity of supply.[29]

While a dramatic increase in quantities of imported fentanyl has played a key role in the rise in drug poisoning deaths throughout the past 5 years, it is important to note that new, even more dangerous illicit street drugs have entered the scene, and are also now playing a role. Of note is a rise in recent years in carfentanil and W18, both of which are more powerful than fentanyl, and carry a high risk of drug poisoning.[30] Methamphetamine use is also on the rise in B.C.- a stimulant that has been regularly cut with fentanyl and other toxic substances.[3] Similarly, benzodiazepines (commonly prescribed to treat anxiety and depression) are being increasingly distributed on the street, and added in problematic ways to fentanyl and other drugs, resulting in increased toxicity of supply.[31]

2.3.2. Safe Supply

In March, 2020, in response to the rise in toxic drug supply witnessed concurrent with the onslaught of

[e] Data for January to November, 2020

COVID-19, BC's then Minister of Mental Health and Addictions Judy Darcy announced new guidelines for prescribers aimed to support drug users with 'safe supply'.[32] These guidelines, which allowed certain eligible populations of drug users to access prescription drugs from limited classes of health professionals, were designed to help stem the risk of increased toxicity death brought about by the pandemic.[33] In September, 2020, these guidelines were expanded, under a pandemic-related 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 – again with intent to counteract the rise in drug toxicity attributed to the pandemic.[34, 35] The new guidelines also allow for registered nurses and psychiatric nurses to prescribe controlled substances. In July, 2021, the province expanded safe supply regulation further, making it permanent rather than a pandemic measure, and offering more opioid options for consumption, including fentanyl patches.[36] While this move is seen by many as a step forward, the fact that this roll-out relies on existing clinical programs to provide safe supply is seen by some to limit its effectiveness. Many physicians are hesitant to prescribe safe supply, and many drug users are dissuaded from accessing such supply in clinical settings. Reliance on clinical programs can be costly, and potentially leaves out rural, remote and Indigenous communities. Furthermore, the new safe supply legislation leaves out stimulants, and does not address the needs of 'casual' users.[37] In spite of the Province's landmark initiatives taken in the roll-out of safe supply, this work has encountered various 'bottlenecks' – resulting from a complex array of issues, such as under-resourcing, and the construction of new protocols and systems, as well as from complications stemming from the need to accommodate of a wide range of drug users, including those in rural and urban locations, those using opioids and stimulants, and those using chronically and casually. These challenges are not entirely unexpected given that "B.C. will be the first province or territory in Canada to pursue safer supply so aggressively".[38] BC's new addictions minister Sheila Malcolmson has committed publicly to the enablement of safe supply programs across the province as a priority – though the realization of this ideal remains to be seen.

2.3.3. Opioid Agonist Therapy

Safe supply, it should be said, comprises a layer of response to the drug poisoning crisis, and can be seen as an extension of Opioid Agonist Therapy – a treatment strategy that has been in-place within B.C. for many years (since 1959), and that involves prescription of opioid agonists such as methadone (Methodose) and buprenorphine

(Suboxone) – long-acting opioid drugs provided in daily doses used to replace shorter-acting opioids such as heroin, oxycodone and fentanyl.[39] OAT has, for many years, been 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; it tracks and monitors patients and physicians, and mandates the concurrent treatment of mental health and addictions.[39]

OAT has been shown to reduce opioid-related morbidity and mortality, with its protective effect increasing as synthetic opioids such as fentanyl become more dominant in the illicit drug supply.[40] Indeed, a recent meta-analysis demonstrated that retention in OAT is associated with two to three times lower all-cause and drug poisoning related mortality in people with Opioid Use Disorder.[41] However, significant barriers to uptake and retention exist.[42] Various of these have been attributed to the quality of OAT service provision. A study conducted by Beamish et al., documents a recent attempt by the BC Institute for Healthcare Improvement's Breakthrough Series Collaborative to, over a period of 18 months, from September, 2017 to December, 2018, improve quality of care in OAT provision in service teams located predominantly in Vancouver - in-line with a series of evidence-based change recommendations. This study showed that particular improvements to quality of OAT delivery, incorporating best practices guidelines, can positively impact uptake and retention of this service.[41] Additional clinical guidelines produced by the Canadian Research Initiative in Substance Misuse advocate an expansion of OAT services to include injectable opioids, arguing this expansion serves as a necessary evolution of OAT, and as a treatment mechanism holding capacity to increase retention rates, and reduction in street opioid use.[43] Recognizing the role OAT plays in preventing drug poisoning amidst a rise in toxic drug supply, work is needed to systemically upgrade service delivery systems throughout the province so as to increase the quality, and therefore effectiveness, of OAT.

It is worth noting that OAT (and by extension safe supply) roll-out often happens differently in large urban centres versus in small cities and rural locales. Best practice guidelines for OAT advocate a 'continuity of care' between a 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.".[44] 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…".[39] Furthermore, OAT delivery in Canada is

tied to contingency management strategies that allow for an 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". For OAT clients in rural/remote locations, barriers exist as related to travel and 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.

2.3.4. Over-Prescription of Opioid-Based Pain Medication

These fragmentations in Canada's response to toxic supply have been compounded, it should be said, by the medical institutions' enablement of increased opioid dependency through prescription. On a global scale, Canada ranks "second only to the US in per capita consumption of prescription opioids".[45] The situation in Canada can be attributed, in-part, to a liberal approach to the prescription of pain medication.[39] 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 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".[46, 47] Between 2010 and 2014, Opioid prescribing across Canada increased steadily by 24%, with 21.7 million prescriptions dispensed nationally in 2014.[39] This increase in prescription rates resulted in a 'massive swell' in opioid dependency.

As regulatory bodies began coming to terms with the damage associated with rising opioid dependency, various measures were enacted 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, in that it introduces restrictive opioid prescribing guidelines (Jones et al., 2020) including recommendations to enter into "opioid prescription modalities slowly, with short durations of use and a maximum dose".[47, 48, 49] Other regulatory initiatives accomplished by Canadian governments (provincial and federal), included reformulating long-lasting oxycodone into a 'tamper-deterrent form' to address concerns related to misuse of OxyContin… and developing/expanding provincial prescription monitoring programs with

enhanced prescriber education. Various of these regulatory responses, it should be said, have been fragmented, given that key elements of health regulations and policy have provincial (vs. national) oversight.[48]

In spite of this fragmentation, government initiatives to restrict opioid prescription were at least somewhat effective in curtailing the practice. 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.[50] 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.[51]

Here, then, we see 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, cultivated displaced opioid dependency and increased demand for (toxic) street supply.

2.3.5. Criminalization

Compounding these issues is the ongoing criminalization, within Canada, the U.S. and numerous nations globally, of people who use drugs. In what follows, I provide a brief history of the legislative and strategic framework that has enabled continued criminalization of illicit substances.

The legal framework for Canada's drug control policy was established in the early 1900's - the Opium Act of 1908 enacted the first drug prohibition, as well as alcohol, tobacco and medicine regulations.[52] This act is seen widely to have been developed as part of a state-wide attempt to control non-British immigrant populations, and to uphold a white bourgeois order.[55] In 1911, The Opium and Drug Act added other opiates and cocaine to the list of prohibited substances; and in 1923, cannabis was added.[52] The ban on alcohol and tobacco was repealed by most provinces during the 1920's, as prohibition was seen as unsustainable and costly.

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, 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".[54] Yet in spite of these counter-prohibition recommendations, the government's approach to drug legislation and enforcement was to become increasingly zealous following the commission's report, and indeed throughout the latter half of the 20th century and into the first decade and a half of the 21st.

Part of this prohibitionist impulse can be attributed to the War on Drugs. In 1986, shortly after U.S. President Ronald Reagan had popularized this concept and made into a policy issue, Canada's Prime Minister Brian Mulroney declared, counter to evidence and popular sentiment, that "drug abuse has become an epidemic that undermines our economic as well as social fabric".[53] 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 – a substantial portion of which was targeted toward enforcement.[52, 55] In 1996, the Controlled Drugs and Substances Act was passed - a soundly prohibitionist piece of legislation that "expanded the net of prohibition further still".[52] And in 2007, the Harper government released the National Anti-Drug Strategy, which removed the harm reduction pillar of the nation's drug strategy, and emphasized "busting drug users [rather] than helping them".[56, 57] This framework of increasingly prohibitionist legislation led to a situation, in 2017, in which drug arrests in Canada totaled over 90,500 - over 72% of which were for drug possession.[58]

The heavy-handed reliance on law enforcement enacted through the War on Drugs rhetoric was seen to have exacerbated rather than have remediated Canada's drug issues. Its punitive approach to people who use substances resulted in the allotment, for possession and trafficking of banned narcotics, of some of the most severe penalties in the country's criminal code - "surpassed only by offences such as assault or murder".[59] Further, the war on drugs was seen to allow police "far broader enforcement powers in even a minor drug case than they have in a murder, arson, rape, or other serious criminal investigation".[60] The increasing harshness of the penalties enacted for drug possession and trafficking, coupled with a stark increase in the police's enforcement power, contributed to a situation in which Canada's legal protections of civil liberties were eroded, as well as its protection of human rights.[52] Additionally, the criminal justice costs

attributable to substance grew significantly between 2007 and 2017 (for policing, courts and correctional services) … in 2017, these costs were estimated at over $9 billion.[61, 62]

It is worth observing that this punitive approach to drug enforcement policy did not apply to all citizens equally. Todd Gordon traces the federal government's evolving drug laws and legislative frameworks throughout the 20th century and into the 21st, as aligned with attempts to control non-British immigrant and racialized communities.[59] "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". The Drug Policy Steering Committee for Toronto Public Health 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".[58] These laws were seen to enforce systemic forms of anti-Black, anti-Indigenous and anti-Immigrant racism. Various studies, such as The Impact of Mandatory Minimum Penalties (MMP) on Indigenous, Black and Other Visible Minorities produced by the Department of Justice Canada support this assertion.[63] Drawing on data from 2007/08 to 2016/17, this research shows drug-related acts as comprising "75% of all offences punishable by an MMP (Mandatory Minimum Penalty) for which offenders were admitted to federal custody"[f]. It shows Black, Indigenous and visible minority offenders as comprising 39% of the offenders punishable by an MMP – a number that far exceeds this same group's 23.4% representation in the general population.[63] Another Vancouver-based study, drawing on statistics from 2020, observes "Black and Indigenous people [as] dramatically overrepresented in drug charges recommended by the Vancouver police".[64] Yet another study, accomplished by the Office of the Correctional Investigator with data from 2017, shows "54% of Black women in federal prisons [as] serving sentences for drug-related offences".[64] While many factors can be seen to have influenced this over-representation of visible minorities in the criminal justice system (including the systemic racism

[f] MMP's are legislated sentencing floors wherein the minimum punishment is predetermined by law. These were implemented, in-part, through the Controlled Drugs and Substances Act; in 2007, Justice Minister Rob Nicholson introduced a bill that placed mandatory minimum penalties for those who commit offences.

intertwined with the nation's criminal justice system at-large), the above-mentioned discrimination enacted through Canada's punitive drug laws most certainly played a role.

Throughout the 90's and into the 2,000's, nations around the world began to desert the war on drugs, recognizing the harms enacted by these policies – including, in addition to human rights violations, the "spread of infections (e.g. HIV)..., damaged environments and prisons filled with drug offenders convicted of simple possession".[52] While international commitment to this 'war' was waning, Canada continued, up until 2016/2017, to develop and enforce thoroughly prohibitions drug laws.

It should be said that at various points throughout this time-period, Canada's solidly prohibitionist stance would be publically, politically and legally challenged, and would cede to various 'allowances'. Such an allowance occurred in 2003, when Health Canada under the Liberal Government, granted the Vancouver 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.[65] 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 overdose prevention sites.[66] These allowances, when positioned against the backdrop of over a century of prohibitionist legislation, appear, arguably, as the first 'trickles' in what would become a river of public and political pressure pushing towards decriminalization, and in some cases, legalization, of personal possession of illicit substances.

The movement towards decriminalization began to pick up speed 2016, when the Government of Canada announced a new *Canadian Drugs and Substances Strategy*, in which harm reduction was reinstated as a major pillar of national drug policy (after having been removed in the Harper government's 2006 National Anti-Drug Strategy).[66] Then, in 2017, the *Good Samaritan Drug Overdose Act* became law, providing protection to people who witness drug poisonings "so that they can seek help, and ultimately save lives".[67] In 2018, in a landmark move, the Justin Trudeau government through the federal *Cannabis Act* made cannabis legal for both recreational and medicinal purposes – making Canada only the second country globally to accomplish this move (after Uruguay), and the first G7 economy (excluding a number US states that have done so outside of US federal jurisdiction).[68] Yet another key anti-prohibitionist step was taken by the federal government in its recent (2021) development of Bill C-22 – an Act to Amend the Criminal Code and

the Controlled Drugs and Substances Act - submitted for First Reading to the House of Commons on February 18, 2021. 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".[69]

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 17,000 lives through drug poisoning throughout the past five years , they are seen by many as 'too little, too late'.[1]

2.3.6. Failure to Decriminalize

Over the past five years, calls have arisen from multiple sectors for the federal government to do more, and move faster, in pursuit of decriminalization. This term holds a range of different meanings, however, common to all of them is the notion that "personal use and possession of drugs is allowed, but production and sale is illegal".[70] Within a decriminalization framework, drug use is positioned as a public health issue rather than as a criminal justice issue. Decriminalization embodies a harm reduction approach, in which people with substance use disorder are enabled to access relevant services in an environment free from the kinds of stigmatization that comes from association with criminalized activity. Under this framework, people found by police to be in possession of small amounts of illicit substances for personal use are enabled to access services, and are supported with community resources, rather than being criminally prosecuted.

A small group of nations who have successfully decriminalized illicit substances are often referenced as beacons in the pursuit of decriminalization. Portugal, through its 'radical' decriminalization drug policy enacted in 2001, is seen to have enacted "dramatic drops in drug poisonings, HIV infection and drug-related crime".[71] In this model, people with substance use disorder are conceived as patients rather than criminals, and connected with a web of social rehabilitation and health services. Alongside Portugal, Czechia, the Netherlands, and Switzerland are among a small group of countries that have decriminalized drug possession for personal use, and invested, alternatively, in harm reduction strategies. The consensus arising from these models is that "decriminalization works"; and yet, few countries are taking the bold step to make decriminalization a reality.[72]

Among Canada's advocates for decriminalization are an increasing number of high-profile players. Notable initiatives of these 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".[73]

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.[5]

2020 (July)

The Canadian Association of Chiefs of Police report Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing Special Purpose Committee on the Decriminalization of Illicit Drugs recognizes substance use disorder as a public health issue, and decriminalization for simple possession identified as an effective way to reduce the public health and safety harms associated with substance use.[74]

2020 (July)

BC's Premier John Horgan, who formally asked the federal government to decriminalize possession of illegal drugs for personal use.[75]

2020 (November)

Vancouver's City Council, which passed a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize the simple possession of drugs. Health Canada agrees to enter into these discussions with the City, currently ongoing.[76]

These individuals/groups and others advocating for decriminalization have, in recent years, exerted considerable pressure on the federal government. Along with skyrocketing toxic drug poisoning fatalities, which are contributing to a shift in public opinion, they are exerting a push against which the federal government is (albeit for many slower than desired) beginning to respond.

Beyond the pursuit of decriminalization, some advocates, such as the Canadian Drug Policy Coalition, through their Regulation Project, are calling for legalization of illicit substances – a move that would see these substances regulated by the federal government in a similar fashion to cannabis, alcohol and tobacco, and made subject to federal production and distribution laws.[77] 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 “impact the enormous profits being made from drugs by violent criminal gangs”.[78] On the other hand, legalization is critiqued by some for its propensity to increase drug use, and to produce harms similar to those enacted by 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 –
made from drugs by violent criminal gangs”.[78] On the other hand, legalization is critiqued by some for its propensity to increase drug use, and to produce harms similar to those enacted by 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 –
including hospital admissions, alcoholism treatment programs and public nuisance”.[79] This argument is difficult to prove, as currently there exists no country that has legalized hard drugs. Given this situation, decriminalization, versus legalization, is often seen as a feasible first step in addressing the drug poisoning crisis from a policy lens.

2.4. Upstream Services - Social Determinants of Health

In addition to ‘downstream’ approaches to harm reduction commonly cited as solutions to the toxic drug poisoning crisis, including decriminalization and safe supply, harm reduction and recovery services, etc., it is important to identify key social determinants of health, or ‘upstream services’ that also contribute to the crisis. Factors such as lack of affordable housing, lack of access to quality mental health services, and lack of quality of education, all play a role in exacerbating the crisis. In what follows, we explore these areas, as well

as, more broadly, the effects of 'hypercapitalism' as a way of being, or not being, together. Readers are asked to acknowledge these areas not as a definitive list, but as a starting-point for a systems-based understanding of the crisis.

2.4.1. Housing

The correlation between the drug poisoning crisis and lack of affordable housing has been well documented. 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".[81] In the Comox Valley, the benchmark price of a single family home was, (as of February, 2021), $631,400 – a 78% increase from 5 years prior.[82] Housing affordability has dramatically worsened the Comox Valley, and is contributing to the exacerbation of health determinants, including homelessness, poverty and addiction.

Recognizing the magnitude of our housing crisis, we are inspired by 'Housing First' – 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 and mental health. While many municipalities have adopted a housing first philosophy, relatively few have successfully implemented it. Some examples of places where this approach has worked include Helsinki, Finland and Medicine Hat, AB, Canada. This approach has been successfully piloted in Helsinki, Finland, and in Medicine Hat, Canada (AB) – both municipalities dramatically reduced homelessness in recent years by providing unconditional housing for people who needed it. Recognized in this move is the positive role housing plays in stabilizing living situations, and enabling people to seek help. As Juha Kaakinen, 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.".[83] While the program is, in its initial stages, expensive, it is ultimately seen to reduce costs related to emergency healthcare, social service and the justice system, saving as much

as €15,000 annually for each person provided with housing.[83] A similar program in Medicine Hat, introduced in 2009, has also led to significant progress - indicated, by "reductions in shelter use, the number of homeless housed and maintaining housing, as well as a number of measures introduced to restructure the Homeless-Serving System".[84] A Housing First policy holds potential, according to many, to stabilize peoples' living situations, enabling them to more fully engage in harm reduction and/or seek treatment and support.

2.4.2. Mental health services

Alongside a lack of access to affordable housing, a lack of access to mental health services constitutes an aggravating factor in the toxic drug poisoning crisis. In 2006, Rural B.C. was acknowledged to suffer from a "severe shortage of mental health services" – a reality recognized again in the Auditor General's Report of 2016.[85, 86]A 2019 BC Coroners Report and report from the Office of the Provincial Health Officer (2019) confirmed this same finding.[87, 88] The Province, it should be acknowledged, has recently, in its 2021 budget, committed to providing $500 million in new funding for "expanded mental health and substance use services", including $152 million for opioid treatment - the largest increase in mental health in the Province's history.[89, 90] 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.

2.4.3. Education

Beyond the issues we've discussed related to housing and mental health, education (or challenges in the provision thereof) is often seen to play a role in exacerbating the toxic drug crisis. It is important to acknowledge here that the Province, simultaneous to suffering the toxic drug poisoning crisis itself, is suffering a crisis in education. Schools in B.C. are chronically underfunded, with the province's current per-student spending average estimated at $1,840 lower than the national average.[91] 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".[92] Simultaneously, the "costs of running the public education system have continued to rise and expectations of schools have increased significantly".[93] 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.[94] The lack of learning specialist teachers is acknowledged as "particularly acute in smaller

communities and remote schools”. This diminishment of educational support is of relevance to the toxic drug poisoning crisis 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”.[95] Given the budgetary crisis outlined above, and the fact that supports for vulnerable students have been eroded, the schools system is, arguably, challenged in its ability to provide adequate support. 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 B.C. school system has worked strategically to develop new models of learning – the most recently-developed curriculum placing 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”.[96] Here, teachers are encouraged to enable students to explore and develop social, emotional and behavioural 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.

Acknowledging this shift, we have nonetheless seen, in this section, the challenge faced by the province’s school system in nurturing and supporting vulnerable children and adolescents - in the wake of a crisis that is, in many adverse ways, impacting their families. By considering children, adolescents and school support systems in our work, we begin to recognize how systemic this crisis has become.

2.4.4. Hypercapitalism and ‘Poverty of the Spirit’

Vancouver-based psychologist Bruce Alexander made headlines in 2008 with his book The Globalization of Addiction: A Study in Poverty of the Spirit.[97] In this piece, written, it should be noted, before the drug poisoning crisis in BC gained official ‘crisis’ status, Alexander posits the rising proliferation of addiction throughout the 20th century and into the 21st as a symptom of a

society whose obsession with capitalist forms of growth and accumulation has resulted in the erosion of the 'social fabrics' that bind communities, families and societies together. Using Vancouver as a case study, a quintessentially 'globalized' city whose economic foundations have been established on principles of global trade and free-market logics, Alexander shows how the City's notorious struggle with addiction has been spurred by a kind of 'hypercapitalism', in which free-market logics have grown to trump logics rooted in social and ecological health and wellbeing. Such logics, he argues, which are now ubiquitous in cities throughout the globe, and 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 need for belonging and collectively-defined purpose as a core human need – one that when not filled results in profound dislocation, and in attempts to 'fill the gap' through alternate means. When market logics are left unchecked, they lead (in addition to ecological devastation) to widespread dislocation, and to the proliferation of addiction as a coping mechanism.

A similar argument is made by physician and well-known addictions specialist Gabor Maté. Like Alexander, Maté posits the roots of addiction as lying in a wider societal context developed through agendas that deny fundamental human needs: "...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".[98] Addiction, mental health struggles, and many forms of physical and emotional distress can, in this view, be seen as a normal response to our failure, as a society, to acknowledge the multidimensionality of human existence. Addiction here is seen to serve as a coping mechanism in the absence of cultures of connectedness, belonging and collective aspiration.

These theorists do recognize, it should be said, the role of human agency in the proliferation of addiction. Both acknowledge individuals as interacting differently within the social contexts they are allotted; some responding to the limits imposed by this framework through the creation of localized networks of connectedness, belonging and collective aspiration; others 'getting by' through engagement with minimally addictive behaviours. But for a portion of the population, the response to this widespread erosion of social fabrics occurs in the form of addictions that play a profound role in people's lives (including drugs and alcohol, but also addictions to shopping, gambling, working, exercise, power, etc.). When allowed to grow unchecked, these serve

to temporarily 'fill the void' left by a society consumed with free-market logic at the expense of human connection. Alexander's response to this widespread social dilemma, it should be said, is not to eliminate the free-market altogether, but rather, to keep the free market in check, ensuring 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 crises endemic to our time.

2.5. Summary

Our exploration thus far has walked through various key dimensions of the drug poisoning crisis as it has unfolded in Canada and B.C. We've acknowledged a dramatic increase in drug poisoning deaths brought about since 2016 when the crisis was, in B.C., labeled a provincial emergency, and 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 Areas. We've seen how a rise in drug poisoning deaths has been fuelled 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 also acknowledged the development of a slate of counter-measures within Canada broadly, and BC in particular, designed to combat fatal drug poisonings, such as the regulation of safe supply, the enactment of opioid agonist therapy, the enablement of overdose prevention sites and interventions, and in recent years, the relaxation of federal and provincial drug legislation. We've witnessed a growing movement, fuelled by a spike in drug poisonings that has stunned the nation, and championed by key advocates such as B.C.'s Premier and the Canadian Association of Chiefs of Police, who are now advocating for a new federal regulatory paradigm and approach to drug enforcement. And... we've examined, briefly, the role played by the 'social determinants of health', and by 'hypercapitalism, in exacerbating the crisis.

In what follows, we switch gears to examine the impact of the crisis in the Comox Valley. Here we have an opportunity to see 'beyond the numbers'; beyond the statistics, and to look at human stories, and to the human impact. Through this glimpse, we have an opportunity, it seems, to

reassess the ways in which we as a community work together towards supporting those facing the crisis first-hand; and to work towards resolution.

3 FINDINGS

The findings outlined in this report stem from research sessions with over 50 participants in the Comox Valley. Participants met together in group and individual sessions, and engaged in a 'cultural mapping' methodology (see sections 1.2-1.7). Groups of participants, including People With Lived/Living Experience (PWLLE), their family members and front-line workers, were hosted by the research team with food, music and art supplies, taken through an ethics consent process and offered an honoraria for their time. Participants were provided multiple levels of support by members of the research team, including a K'ómoks Elder/Knowledge Keeper, Outreach Workers, Peers, Artists, and a Community-Engaged Researcher, as well as by our partnering social service organization, AVI Health and Community Services. In the sessions, participants were asked to respond to the central research question: "**How has the drug poisoning crisis impacted you and your community?**". The researchers then asked follow-up questions, where participants were asked to speak to the themes and concepts shared through their drawings, or stories. The following chapter outlines key insights emerging from these recorded sessions. These reference many of the concepts outlined in the literature review, and illustrate how the drug poisoning crisis is uniquely impacting the Comox Valley.

3.1. Lived Experience of the Crisis

While many of the concepts and debates stemming from this crisis are applicable to communities at-large, the crisis is, we recognize, uniquely experienced by each community. The following section speaks to the ways in which the crisis is felt within the Comox Valley. The stories come from people located in this place. While we do not claim to represent the full story of this experience, we offer a window based on the insights shared by our participant base. The narrative is seen as a starting-point; more work is needed to evolve our understanding.

Before launching into these findings, it is important to honour and acknowledge the participants who boldly gave their stories and insights.

Our team is honoured to have received these– which were given with immense courage, and with intent to spur change. Our circle has borne witness to these stories/insights, and we ask those who read them to do so with respect – acknowledging the impact of this crisis on individuals and families; and the need to come together in ways that are creative, visionary and compassionate, towards the formation of new ways forward.

3.1.1 Fentanyl and drug mixing: 'A different ballgame"

Across the board, participants spoke to their experience of the crisis as worsening in recent years. The rise of fentanyl was cited by many as a key factor exacerbating the crisis - acknowledged to have contributed substantially to the toxicity of the drug supply. Furthermore, it was seen to have triggered more severe forms of addiction, and to have caused extraordinarily negative physical and psychological consequences for those who use – including a higher rate of drug poisoning, and along with this rate, higher levels of mental and physical damage. Dr. Kindy observes:

The difference from 20 years ago to now is, when people would come see me... when they had Opiate Use Disorder, they had survived their substance use for many years... You could basically do heroin for a long time and function for a long time. And your brain wasn't harmed if you didn't do, like I would say, too much, and overdose. So the patients I would see were usually a bit older. And at that point, they had had enough, and they were ready to come into the program. Now what I'm seeing is late teens, or early 20's, that within two or three years, the consequence of their use is extraordinary. I mean, if you have them on the program for two years... if they continue using, the change you see is scary, to be honest with you. And I think that part is a crisis. And again, we have to remember when those kids overdose, there's a brain injury. You keep overdosing, there's going to be some changes, and those changes, some of them are gonna be permanent. (Dr. A. Kindy, personal communication, September 9, 2020).

The rise in fentanyl and its impact on drug poisoning is seen by Dr. Kindy to have dramatically changed the landscape of addiction in the Valley. In addition to its role in spurring brain damage, Dr. Kindy speaks to the very real forms of physical damage caused by the introduction of this substance:

You know, [under the new scenario], I've had patients doing really well, for a number of years, relapse once, relapse twice and then never see them again. Next time, you know, they're in the hospital getting an amputation. And they're like, 26, right? So it's a different ballgame. (Dr. A. Kindy, personal communication, September 9, 2020).

In addition to this enactment of mental and physical damage, the rise of fentanyl was seen to complicate the

provision of Opioid Agonist Therapy (OAT) – causing a reduction in its effectiveness:

The other thing that I'm seeing in my practice is that if people relapse with heroin, with OAT, it would block the heroin, and often they would come back and they would function. So the harm reduction worked, versus fentanyl, which is a different ballgame... (Dr. A. Kindy, personal communication, September 9, 2020).

Dr Kindy speaks, then, to the onslaught of fentanyl as having profoundly negative implications in relation to the maintenance of OAT.

In addition to the rise of fentanyl on the street market, drug mixing was also seen as an emerging trend whose increased practice is having devastating effects. When asked about the key hurdles at-play in her work treating clients with substance use disorder, Dr. Hemmerich states: "Increasing toxic drug supply with more carfentanil laced with benzos" (Dr. E. Hemmerich, personal communication, August 13, 2020). Dr. Kindy supports this view, noting the mixing of increasingly toxic drugs as causing people to "take a lot longer to get better".

Similar insights were echoed by participants with lived experience, who point to the ways in which new forms of drug mixing are diluting, or diminishing, the effectiveness of dominant drug poisoning prevention strategies such as Naloxone/Narcan.

Say you're an heroin user, and you get heroin with fentanyl in it, but maybe it has Xanax in it as well, because things are just being mixed. You have no idea and then when you try and Narcan someone it doesn't work because there's benzos in their drugs, and like that's what happened to my best friend.... It doesn't matter how many times you Narcan them, they're not coming back. (S. Katsanikakis, personal communication, December 17, 2020)

The mixing of drugs, as noted by Sophia, has contributed significantly to the toxicity of the supply. A PWLLE, Daryll, echoes this sentiment:

Back in the day, nobody knew what [fentanyl] was. You just cut it with something that didn't harm you. And now they're cutting it with stuff that does harm you.... Like this pig dewormer and all this stuff, like why would I want that shit? To put that in someone's dope if they're gonna die from it, or get sick from it, or get something from it. I don't want to do that. It used to be all the sugars, right? ... Now they're using more powerful dope that brings back more of the drug than what they put in. How does that make sense?... (Daryll, personal communication, November 5, 2019)

In short, the introduction of fentanyl into the street drug scene in the Valley, coupled with the mixing of drugs, was seen by a number of participants to have evoked profoundly negative consequences for drug users – including severe

consequences for drug users – including severe mental and physical consequences, reduction in effectiveness of OAT, and the need for extended treatment times and strategies.

3.1.2. The experience of drug poisoning

Numerous participants spoke to the impacts of toxic supply by describing, often in vivid detail, their experiences of drug poisoning. These personal experiences may evoke strong emotions; readers are asked to engage with discretion:

> **When I overdosed that time, I just flopped on the ground and started banging my head on the door, and my roommate got me and threw me in the bathtub. And he was like what's happening? Like, what's going on? And I could just make out that it was drugs. And then my girlfriend at the time came, and just the look on her face, I'll never forget how scared she was. And so she took me to the hospital, and they didn't want to take me in emergency. They're like, "Oh, he's fine. Take him". But I was pretty incapacitated. I was messed up. They didn't want to take me. So that was my experience with the stigma in the healthcare system. They were like "No, he's fine. We don't want him here."....You know, I didn't have Narcan or anything like I just, I had this in my system. And you would have thought that that would have learned me, you know, about the poison and how dangerous it is, but it didn't. I think within two weeks I was using again, and I overdosed again...(L. Eaton, personal communication, December 16, 2020).**

Here is described a traumatizing rejection by someone seeking medical assistance in the midst of a drug poisoning. This trauma – defined by a threat of death, of inflicting pain on his loved ones and of rejection, is often-times experienced perpetually by people who use drugs, and can be seen as a kind of 'cloud' that persistently threatens to take that which is most valuable: life, family, community. The following story shows one individual's struggle as he grapples with multiple consecutive drug poisonings:

...I O.D'ed... I died. And somebody found me. And I don't know how they did it, but they did... So the door was closed, and the lady pushed the door and it wasn't locked. She walked in and found me dead on my bed. And I was cold as can be, blue as can be she said. It took, I dunno, five Narcan shots at that time, to bring me out and then go to the hospital. Well actually, I never did come to. I came to in the hospital at 5:30 in the morning. And I wasn't breathing, right? They thought I was dead for sure. Thought I was gonna have to go on a breathing apparatus. That's what they thought was the next move... That was the first time I O.D.'ed, and it only took me four more times to get to it. And that was in my room, and the last ones were all in the bush or somewhere, somewhere where nobody even knew I'd be. (Daryll, personal communication, November 5, 2019).

These harrowing accounts speak to the traumatization that toxic drug poisoning is enacting. To experience drug poisoning, often perpetually, to be turned away from medical help, to be made subject to a continuous supply of poisonous drug supply, and to have experienced a prolonged loss of oxygen... these circumstances are unimaginable, and cause unimaginable levels of trauma and distress – both for the individuals to whom they occur, and for those surrounding them.

3.1.3. The Medical System's Role

While clearly the drug poisoning crisis can be attributed to a rise in potency and complexity of street drugs (and their mixing), many participants highlighted, as well, the role of the medical institution in feeding the crisis. As one participant with lived experience observes

Doctors are the worst drug dealers out there. And they get paid to do it (Trigger, personal communication, March 18, 2019).

Many participants spoke to the role of doctors in 'prescribing' the crisis into its current out-of-control state:

From the hundreds of people I've spoken with on the streets, that are addicted to opiates, you know, 65% of them or more, always have the same story. They were injured or were given Oxycontin or all that stuff. And crazy high amounts – (S. Franey, July 9, 2020).

While much has been said, then, about the threat imposed by the toxic supply of drugs, including of fentanyl, and of the mixing of drugs, it is important to also keep in mind the medical system's role in fuelling this crisis through over-prescription.

3.1.4. Stigma

Stigma was identified by numerous participants as a key barrier preventing drug users from seeking help in the medical health system, and as a regressive form of social behaviour that resulted in people who use drugs feeling isolated and socially denigrated. The term 'stigma' is defined by Webster's Dictionary as "a mark of shame or discredit".[99] It is a Greek word that historically has been used to describe markings or tattoos burned or cut into the skin of criminals, traitors or slaves.[100] This knowledge brings to the world a visceral association with notions of 'outcast', and speaks to the level of disenfranchisement, disdain and 'othering' experienced by the substance using community. The following quote by participant with lived experience, Evan Mayoh, illustrates the power of stigma in 'dehumanizing' the drug using community:

"I think, first and foremost, we need to get this dehumanization thing completely eradicated.

Photo by: Nadine Bariteau

These words provide insight into the strong feelings of rejection and dis-connection imparted to people with lived experience through stigmatization. Through stigma, people are dehumanized, and are treated as unwanted; as 'less than'; as 'trash'.

3.1.5. Stigma in Health Care

This 'dehumanizing' impact of stigma is evident in many different domains – and appears as especially acute in relation to the health care system. Numerous participants spoke of the lengths to which they will go to avoid accessing medical services in response to drug poisoning:

There's a lot of times that I've been places, and I feel I've done, you know, 12 Naloxones and we've never called [emergency medical services]. And I've been Naloxoned once myself and we never called it in. A lot of that goes under the radar too. You know, because of stigma, and then you don't want the police and the paramedics coming there to where you're at and stuff like that.... Yeah, it's just like, bring them back, or, if necessary you just keep hitting them, hitting them, hitting them. Like some people have been hit 11 times with Naloxone to bring them back. Finally, they came back. And, you know, a lot of the time, they probably weren't getting CPR while they were getting hit. So there's some brain damage every time, you know? So there's a lot of that going around too, just because of the stigma. (Trigger, personal communication, March 18, 2019).

Not only are users often afraid to call for help after responding to a drug poisoning, many also hold a strong fear of entering into, and engaging with, hospitals. The following account, which speaks to one participant's experience seeking help in hospital, is similar to many of the stories told by lived experience participants:

I've had many experiences with the hospital and going to the hospital. And the emergency room in particular. I haven't had any experiences at the new hospital, so I don't know if things have changed. But I do know that when St. Joseph's was in Comox, there were several times, one time in particular, I was there for mental health issues. I was brought there by an ambulance. And from the minute I got in there, the nurses were telling me, “you're not getting any drugs, you know, you're not getting any drugs”. And I was not really in a position to really answer them coherently. And they just made me wait, kept telling me that I was not going to get what I wanted. And that I should probably just leave, I kept insisting to see a doctor. When the doctor came, finally, after several hours, I was the only person in the emergency room, there was nobody else there. No other patients, just a couple of nurses, myself... and the doctor looked at me and talked to me for maybe two minutes, told me he wasn't going to do anything for me, and that was it. After that the nurses were literally kicking me out. It was about three o'clock in the morning on a winter's day in January.

Photo by: Nadine Bariteau

And I had no money for a taxi. And I kept asking, if I could... I had no coat on. I kept asking if I could just sit in the waiting room until the buses started in the morning so I could get home. After arguing for about 20 minutes, they called security and forcibly removed me from the hospital. So the only thing I could do is go across the street to the bus shelter, there's a bus shelter across the street, and put on my hoodie. I had a hoodie on and put my arms inside and pull it down over my legs and curled into the fetal position on the bench there until it got light. As soon as it got light, I was so cold that I thought it was still too early for the buses. So I just stood outside the bus shelter. And thankfully a nice lady on her way to work, stopped and picked me up and drove me all the way home, which was nice. But at that point, I was just, I could barely move I was so cold. So I've spent about three hours, that was about six o'clock in the morning, six, seven o'clock in the morning when I was picked up. That's been my experience of the emergency room. Pretty much every time I've been there. (P. Sture, personal communication, June 30, 2020).

Photo by: Nadine Bariteau

This story of rejection, and of an apparent lack of concern on the part of the medical system for this individual's wellbeing (as expressed, for instance, in his physical removal from the hospital in the middle of a winter night with no provision for his transportation, physical wellbeing or security), brings to light some stark realizations pertaining to the inherent biases and stigmas ingrained within many such institutions. The hospital (as a construct), and the emergency room in particular, constituted one of the key recurring sites in the Valley identified by participants as a place where power dynamics rooted in stigma were played out. One participant, who had taken an unhoused, using friend to the hospital to address injuries that had been inflicted through an attack, observed the dehumanizing way in which this friend was received within the emergency department:

I will always remember the ways in which the emergency room staff treated [Anonymous PWLLE]. I will remember that forever. And this is somebody who came in bleeding like crazy from his head, and was not offered a gauze until maybe 15 minutes later. I went with him and got him a box of tissues...he was bleeding on their floor. (Anonymous, personal communication, June 30, 2020).

Similarly, the following insight provided by a family member shows how the process of engaging with the hospital as related to a family member's addiction is at times accompanied by instances of shaming on the part of staff:

As we've shared Ryan's story, we've heard people say the treatment they've got from the medical profession, what disrespect they get about their concerns, how they are shamed and blamed if their child comes to the emergency room. And the emergency nurse says: "Well, they are wasting our precious time". And the mom says "If you don't think my child arriving here full of narcotics, and I didn't know about it, isn't an emergency, I don't know what it is". But it's those stories that are heard again and again. (Jennifer Hedican, personal communication, July 14, 2020).

These instances of shaming were often seen to be accompanied, as well, by the provision of sub-standard systems care, such as in the failure to provide a hospital bed, and the hosting patients in the hallway:

I had taken Ryan to the hospital at one point. Because he was sick, in detox. And he wanted Suboxone. And he wanted to feel better, and he wanted to detox. And we sat in the emergency room, six, eight hours. And nobody really came to look at him. He was given a little room to lay down in as he was in pain. On the floor, there was no bed. And they gave us a card and said here, you can contact the nurse at the nursing centre. And she'll return your call in a couple of weeks. And then you can maybe see the doctor up in Campbell River. And that was it. So the

message that's given to the person is "you are not valued". And that was really so unfair, and it is still unfair. (Jennifer Hedican, personal communication, July 14, 2020).

Dr. Kindy speaks to the frequent hosting of substance use patients in the hallway as indicative of the frequent diminishment of addiction in relation to other forms of illness:

I think because of the lack of beds, there's so much acuity that even people with addiction are considered lower on a totem pole... you'll be put in the hallway, which is unacceptable. Right? So that definitely needs to change. (Dr. A. Kindy, personal communication, September 9, 2020).

It is important to note that this provision of sub-standard systems care (ie: denying patients beds, placing them in hallways) was accompanied, in some cases, by stories in which stigma was actively combatted – stories, for instance, in which nurses went out of their way to help. Such interactions were seen, however, as the exception rather than the norm.

On the whole, then, stigma was seen to significantly compromise the front-line health systems' ability to respond to people with substance use disorder. Calls were made by participants for radical improvements to be made in relation to the health care system's treatment and hosting of people who use drugs; Dr. Hemmerich, for instance, speaks to the need for more education to be provided to workers healthcare settings:

People are still being treated poorly in emergency and in hospital with a lot of stigma. And there needs to be so much more education for the healthcare providers, to start to change that. I feel often very upset for my patients, how they've been treated. (Dr. E. Hemmerich, personal communication, August 13, 2020).

Here, then, we see played out, in accounts describing interactions (or lack thereof) with emergency medical and hospital services, the enactment of stigma on multiple systemic levels. The accounts of stigmatization are in many cases so strong that they discourage people from accessing medical services. Work is clearly needed to transform the hospital, along with other health services, into spaces of acceptance for people who use drugs.

3.1.6. Stigma in Policing, Civic Services and the General Public

Stigma was also seen to be present in social systems such as policing and in civic services related to downtown, as well as in a culture of rejection expressed by the general public. Often the references to stigma were related not only to substance use, but to

homelessness:

What I've been going through in the last week is... the system and the stigma behind it, it's horrifying. Walking down the street today. Staggering down the street, and it's not cause of booze, and I got picked up by these RCMP girls. Mean well, I guess. But they also need to keep their jobs. (Anonymous, personal communication, November 2, 2019).

This participant speaks to a kind of routine targeting of people who are non-conforming; people who look or act different; people who 'stagger'. This targeting is seen by some to be part of the ongoing work of the RCMP; as almost a make-work project. Others echo this view:

I spent this morning with the cops. Cut me off in a wheelchair and then blaming me for all the stuff and not recognising I got a broken leg, I'm in a wheelchair (Barry, personal communication, November 2, 2019).

I've experienced, not recently, but in my past, I've experienced years of years of abuse from the police. But yeah, I still hear the same abuses going on. (P. Sture, personal communication, November 2, 2019).

Not only were police often seen to hassle people who use drugs (especially those who also are without homes), they were seen by one participant, at least, as largely unhelpful in pursuing any kind of justice on behalf of those same individuals:

You can be guaranteed that the cops aren't going to lift a damn finger to try and track down somebody who trashed your homeless person camp. Because in their eyes, they're like, well, good, whatever, maybe they'll smarten up or something or go away. (E. Mayoh, personal communication, October 11, 2019).

Here, then, we see articulated an unjust relationship between the participants with lived experience and the police – a relationship characterized by a type of badgering on the part of the police, and by an unwillingness to play a legitimate law enforcement role when needed.

Similar stigmatized interactions to those attached to police were acknowledged in relation to civic services – particularly those located in the downtown core. Participants with lived experience spoke extensively about the difficulties they've had in accessing such fundamental services as water, a washroom and power supply, as well as a place to camp. A reduction in, or retraction of, these services was seen to present a clear message to those who use them:

The [washroom] in Lewis is only open for the summer, they already locked it. They never open it in the winter period, because baseball is over.... Yeah, there used to be lots of little hose tap things, but they're systematically removing them, either straight up, or they're taking the little wheels off, or they're putting lockboxes around them, so you can't even get access to water. And it's like, wow, really? Like, I get being really, really vindictive, and you know, shutting down your external outlets, so that, like, we can't even charge our phones. And you know, that's like, 2000 milliamp hours, it's nothing. They keep their business lights on all night, every night. And that's orders of magnitude more energy than, you know, a couple of people plugging their damn phones in for, like, half a charge is gonna ever be on them. So they're removing power outlets, they're locking up the stuff that they threw away because they didn't have a use for and didn't want any longer, and they're taking away water access. And it's like, wow... And then on top of that, they're displacing people constantly. And they're turning the Valley into less and less of a beautiful place in order to do it, because they're ripping out the little nice wild spaces and pockets and stuff that you find scattered around...Is it really worth you know, completely clear cutting the valley's natural beauty in order to get rid of them? .... (E. Mayoh, personal communication, October 11, 2019).

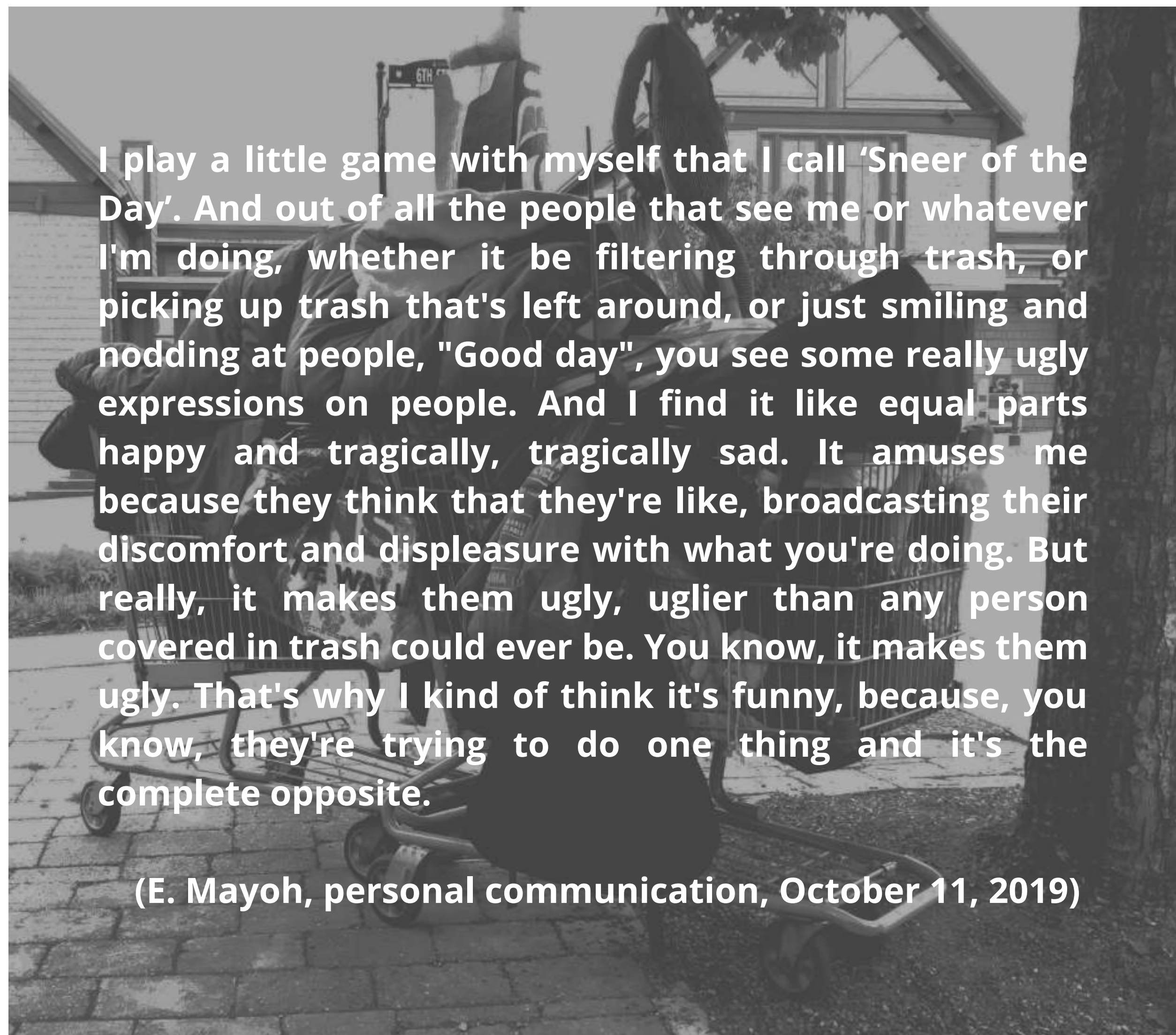
Participants did show appreciation for the accessibility of several key services: the rec facility showers and the soup kitchen, for instance, were acknowledged by Evan as "pretty decent" (E. Mayoh, personal communication, October 11, 2019). Overall, however, we see a picture emerge wherein civic services are perceived as becoming increasingly inaccessible. The act of limiting and/or diminishing access to public services like washrooms, water, electricity and/or places to camp, sends a clear message to people who use drugs and are unhoused – 'you are not valued; you are not wanted here'.

Finally, participants with lived experience spoke at-length about the stigmatization they received from the general public – often in relation to their perceived homelessness or joblessness. The following quote demonstrates troubling acts of aggression and discrimination enacted by Comox Valley public in relation to people who use drugs and/or are street-involved:

[Anonymous PWLLE] and I were in a tent three weeks short of a year. We got so much flack from people that would know where we were behind Walmart for about eight months. And then we went out to Fanny Bay to a place which was not

good. We went with a landlord that's known notorious for being a slumlord and such. But we took the chance hoping that he'd fulfill you know, the basic necessities, but we didn't even get that. We didn't even have running water. We didn't have windows and such. So we moved on to the pump station. Comox Road. We'd have people drive by honking their horns and calling us awful, awful people and how we were disgusting and we should get a job. And you know, that would make everything right I guess, having a job. (L. Chapados, personal communication, October 20, 2019)

And Evan speaks to a game he plays that demonstrates the extent of the stigma he faces on a daily basis:



I play a little game with myself that I call 'Sneer of the Day'. And out of all the people that see me or whatever I'm doing, whether it be filtering through trash, or picking up trash that's left around, or just smiling and nodding at people, "Good day", you see some really ugly expressions on people. And I find it like equal parts happy and tragically, tragically sad. It amuses me because they think that they're like, broadcasting their discomfort and displeasure with what you're doing. But really, it makes them ugly, uglier than any person covered in trash could ever be. You know, it makes them ugly. That's why I kind of think it's funny, because, you know, they're trying to do one thing and it's the complete opposite.

(E. Mayoh, personal communication, October 11, 2019)

Photo by: Nadine Bariteau

Here then, we see the multiple ways in which people who use drugs and are homeless are stigmatized and dehumanized – within the health-care system, policing, civic services and by the general public – through overt, subtle and systemic acts of discrimination. We've witnessed accounts in which people with lived experience are provided substandard medical care, hassled by police, stripped of access to essential services such as water, and derided, or 'sneered at' by community members – all of which was seen to have profound negative impact on individual and community health and wellness.

3.1.7. Racism

Up to this point, we've received stories of stigma generally, as related to people with lived experience of addiction and homelessness. It is important to note, however, that for many Indigenous participants with lived experience, these acts were often seen to include elements of racism. Many participants spoke at-length to instances of racism they had faced within the medical system, including being denied quality care in hospitals, and dismissed by front-line medical staff as 'drug seeking'. As a participant with lived experience observes:

"Just last weekend, I was told, or I had overheard that I'm there [in hospital] for the drug use. And I'm not, I just want to know what's going on with my body ... the racism will never stop. (Anonymous, personal communication, March 8, 2020)

Indigenous participants shared, as well, stories similar to a story shared earlier, of being 'let go' from hospital, often in the middle of the night with no transportation options, often in winter; and of being offered substandard medical service:

This discrimination - having to walk home from the hospital. Asked for cab fare and they said "No, we don't hand those out anymore". And it took us three and a half hours to walk home. My daughter had a back injury. I didn't even have my walker with me. We walked all the way down Ryan Road in the dark, make our way home and it's like, I live at the junction. (Mama Bear, personal communication, March 8, 2020)

This lack of care on the part of the health system, especially as related to the ways in which patients are discharged from hospital, was raised multiple times by Indigenous participants. The risks of uncoordinated and abrupt discharge were seen, by most, to be unacknowledged by those in positions of power. An anonymous outreach worker notes the devastating consequences such release can have for Indigenous Women:

For Indigenous women, when they're put out on the street like that, they put them at great risk. We are in the midst of a crisis involving missing and murdered Indigenous women, and to have women out on the street like that, in the middle of the night is really dangerous. I think there needs to be a lot more cultural training and cultural competency training, when you're going to send somebody out in the street. Know their vulnerabilities and what you're putting them at risk for (Anonymous outreach worker, personal communication, March 8, 2020).

In these accounts we are presented with a system that fails, in many cases, to provide essential care to those who seek it; that compromises human dignity, and that fails to take into consideration the cultural context in which people are seeking care.

3.1.8. Loss of Trust – The Impact of Residential School & Inter-generational Trauma

For many Indigenous participants with lived experience, the stigmatization and racism residing within the present-day medical system was traced back to histories of colonization, including to the legacy of Residential School and its resulting intergenerational trauma. The following account, delivered by Elders who had been forced as children to attend residential school, provides important context:

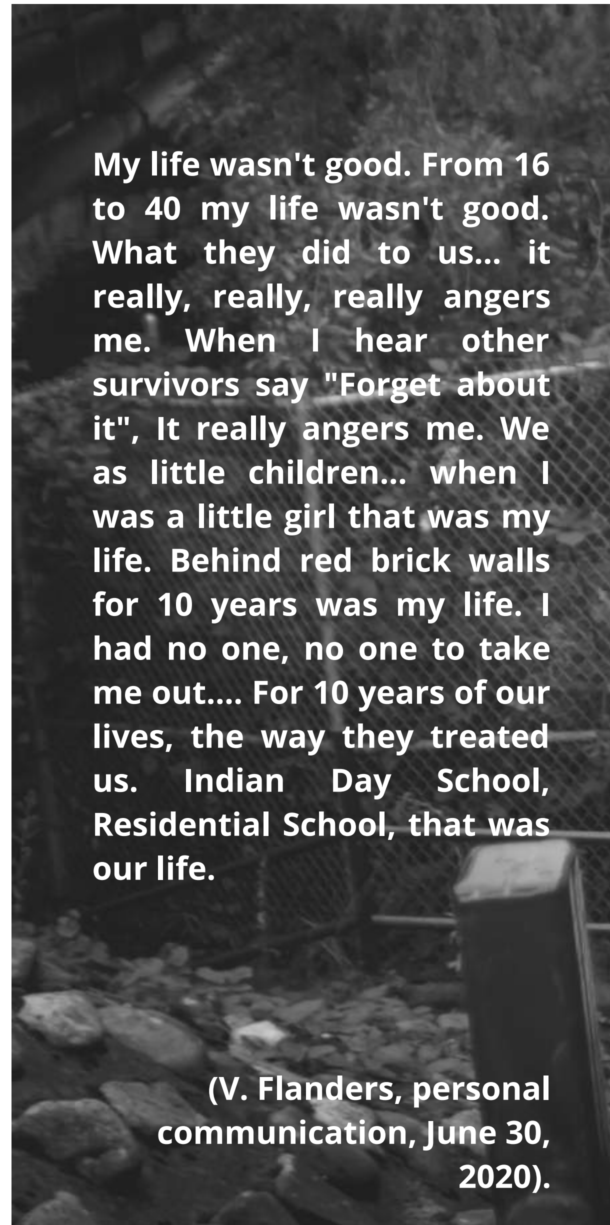


Photo by: Kyle Little

In this account, we are asked to consider the history of oppression brought about by systems of colonization. Such a history has led, in the view of several participants, to a profound distrust in contemporary social, medical and judicial systems:

We don't trust them. In the school system, in the hospitals. We don't trust the judges and the lawyers and the cops. We don't trust anybody. The only people we trust is ourselves and they don't seem to get it, because they gotta earn our trust. "Well you've gotta trust me Verna." I said "Never! Never. I will never trust anybody ever". Especially a cop or a doctor or a nurse. They've done wrong to all of us First Nations people, all of us. None of us escaped it. None of us. (V. Wallace, personal communication, June 30, 2020).

In these powerful words, we see demonstrated the impacts of colonization and dehumanization imposed by Residential School and continuing through generations into the present-day structure of medical and policing systems. In the unthinkable acts of violence and cultural genocide these institutions imposed, we see their systemic production of racism. The trauma inflicted on participants through this legacy was seen by some to enact realities in which depression and dispossession were considered a 'norm', and in which drug dependency was considered a logical escape. As one young participant states:

The thing is, if your natural state of mind is something that's depression, you're gonna want to alter. Alter your brain chemistry and get high and just feel different than depressed. So almost everyone I know has done drugs, or is doing at least something, whether it's drinking, weed or hard shit. (Anonymous, personal communication, March 8, 2020).

Here we are asked to consider the ways in which colonial violence is passed down through generations of families, and in which colonial logics continue to be re-produced within contemporary institutions – whether they be medical institutions, justice institutions, etc. Colonialist histories can here be seen here as implicated in both the distrust held by many Indigenous participants with contemporary health and social systems, and of the racism enacted through these systems.

3.1.9. Cultural Safety, Cultural Knowledge

A response to these systems of colonization and racism as embedded within the health care system is found, according to one participant, in a radical uprooting of existing health care, such that an acknowledgment of the importance of alternative Indigenous ways of healing can occur:

When we go to the doctor, we often don't get offered alternative medications, like different therapies or more holistic, nature-based healing, traditional land-based healing. A lot of times, it's "here to take this pill and go fill this at the pharmacy". There's really very little follow up care. Just check in with your doctor type thing, and they might give you more medication. But I think we need to

look at health in a more holistic way. (Anonymous outreach worker, personal communication, March 8, 2021).

This quest for holism was equated, by some, with the restoration of 'old ways' of healing; ways that have been used by Indigenous communities since time immemorial:

We need to go back to some of the natural healing ways, the old ways, to bring balance. There needs to be balance and healing from all the trauma that people have experienced. So, when we go to the doctor, or we go to the hospital, we need to be offered cultural healing ways, not just a medication. (Anonymous outreach worker, personal communication, March 8, 2021).

Several participants spoke to the medicine wheel as a key symbol of multi-faceted healing – of a kind that takes into consideration not only the physical, but also mental, emotional and spiritual dimensions of a person.

Through these accounts, we begin to understand something about the link between colonial systems of oppression, intergenerational trauma, and the racism encountered by Indigenous participants within present-day medical systems, and in relation to the drug poisoning crisis in particular. We are asked, through these stories, to see addiction not as an 'individual' issue but as one rooted in collective histories of colonialism, oppression and racism.

We are invited, through these accounts, to consider ways in which our biomedical system, whose focus lies primarily in western notions of health, might be altered to accommodate the wisdom of ancient Indigenous healing systems, and of multi-modal understandings of health and wellness – leading to more equitable and compassionate, and less stigmatized and racially-biased, systems of care.

3.1.10. Signs of Change

Against the backdrop of the stigmatization and racism attributed to these systems, some participants offered hope that systems are, slowly, changing. Dr. Kindy speaks to the ways in which the medical system at-large is being re-conceptualized in the wake of the drug poisoning crisis:

What I'm seeing, the big difference from 20 years ago to now, is we're actually treating it [Opioid Use Disorder] as a disease, which I think is fantastic, right? So more resources are applied to try to treat this disease. I think the stigma is still there, but it's being talked about, which I think is a first step to try to get rid of that stigma. And I'm seeing the medical community changing. I mean, there's always people that will not change, because they're so ingrained in their way of being. But what I'm seeing is a lot of the new physicians are being trained in addiction, and they're much more open to the idea that it is a disease. And they're treating, hopefully, people with substance use disorder in a more

respectful way. I'm seeing that more.... And I'm seeing more resources as well put into the system to improve the situation. (Dr. A. Kindy, personal communication, September 9, 2020).

Dr. Hemmerich echoes this hopefulness, pointing to new movement in the healthcare system designed to reduce stigma:

We have a family practice residency program here in the Valley, and we're going to take on residents into our clinic. We have an addiction medicine consult service now at the hospital for the past year. It's also really positive for reducing stigma in hospital to patients (Dr. E. Hemmerich, August 13, 2020).

Some noted that there have been marginal gains in recent years within the healthcare system at large, and within community-driven outreach, in acknowledging and combating racism and stigma, however, most emphasized the need for much more progress to be made.

Programs like Unbroken Chain – Indigenous Women's Sharing Society's Indigenous harm reduction program, were seen to provide a unique model. This program provides culturally-informed ways forward, including harm reduction supports based on Indigenous practices and principles of harm reduction that support the whole community:

We do it in a holistic way. We're meeting people where they're at, building connection is basically the foundation of it, and I think that goes a long way. When people feel supported, they can heal. I haven't seen any other way to do it. (P. Alvarado, personal communication, March 8, 2020).

Acknowledging these 'glimmers of hope', it is clear that much work remains to be done - to re-imagine, and re-develop a response to addiction that embraces multiple ways of knowing and understanding. Such a system must have at its core a fundamental respect for those facing this crisis first-hand, as well as the inclusion of alternative, holistic and culturally-informed healing practices.

3.1.11. Summary

In this section, we've explored multiple ways in which people at the heart of this crisis – people with lived experience, family members and front-line workers, experience the crisis in the Comox Valley. We've received first-hand accounts describing, from various angles, the destructive impact of fentanyl as it has entered into the street drug scene in the Valley; but also the impacts brought about by the 'complexification' of the drug scene through the mixing of drugs. We've received first-hand accounts of drug poisoning, and have learned about the heightened levels of threat and trauma that people who use drugs often live

with on an ongoing basis. Furthermore, we've received stories about ways in which stigma and racism are played out in the Valley – through systems such as health and criminal justice, and as activated within the general public. We've received accounts of the ways in which people are cared for (or not), within these systems – with many speaking to their experiences of care as steeped in stigmatization and inequality. While some glimmers of hope exist, in which health and social systems are being seen to embrace progressive understandings of substance use, much work remains to be done - to combat histories of stigma, oppression and racism, and carve out an approach to addiction that is both trauma-informed and culturally safe.

In what follows, we look at some of the 'big system ideas' that have emerged as solutions to this crisis – including notions of 'decriminalization' and 'safe supply'. We show how participants in the Comox Valley interact with, and think about, these concepts, and how they might be taken up by local systems of change. We then move into a discussion of the landscape of services provided within the Valley (those directly related to addiction) including identifying some key gaps and opportunities within this community's service provision ecology. We augment this analysis with an exploration of the 'upstream' services (those playing a determining, rather than direct, role in addiction). We end, finally, with a series of recommendations that build on the knowledge gained through this research.

3.2. Decriminalization & Legalization

As our province and nation grapples with the drug poisoning crisis in its multifaceted dimensions, many have pointed to the need for policy reform – specifically, for the decriminalization of minor amounts of drugs for personal possession, as a way to make traction on, and reduce the number of deaths enacted by, the crisis. By decriminalizing substances for personal use, the drug poisoning crisis becomes recognized as a public health crisis rather than a criminal justice crisis – an important shift in enabling those most impacted to come forward and seek help. Section 2.3.6 of his report provides a history of this movement towards decriminalization within the Province of B.C. In what follows, I augment this history by outlining some of the key positions held by participants in relation to decriminalization.

The majority of participants in this project, including people with lived experience, family members and front-line workers, supported decriminalization as a viable step forward in addressing the crisis, with many moving a step beyond and advocating for legalization. Indeed,

Barb and Louise

Photo by: Nadine Bariteau

criminalization of substance use was seen as a key generator of stigma – for people who use drugs (generally), and especially for those whose professions require public accountability:

There's a lot of drug addicts that hold full time jobs, quite awesome professions. Nurses, I know a lot of nurses that do a lot of hard drugs, you know, inject them...And I know lawyers and cops, and once the stigma gets dropped, and the fear of it being a criminal thing gets dropped, then you'll see a lot of people come out of the woodworks and admit that they're shooting up, or they're addicted to this drug or that drug. And you wouldn't have expected it, and they were always using by themselves, hiding it from everyone...they're probably more at risk than those on the streets, really. (S. Franey, personal communication, July 9, 2020).

In this view, the decriminalization of substance use would go a long way in mitigating the shame and fear people who use drugs have in relation to seeking help.

A second perceived benefit of decriminalization pertains to the increased influx of funding to be gained towards treatment and harm reduction as a result of the diminishment of criminal prosecution costs:

We need to quit wasting all the tax dollars, the billions that we spent fighting, that changes nothing. And the costs of incarceration. Because there's so many supports, and mental health issues, and homelessness that aren't funded And we spend all that money trying to change something that will never change. (E. Mayoh, October 19, 2019).

Through decriminalization of substances for personal use, not only is money made available to re-allocate into the health of substance users, the net benefits to society are seen as immensely positive. An Anonymous PWLLE states:

In my mind, I think if more drugs were legal, and regulated, I think you could lower the amount of people that are actually becoming addicted. There's countries in the world that have gone that way. And they legalized certain hard drugs, and the amount of people addicted didn't go way up, it went down. And they had better treatment and better mental health care. (Anonymous PWLLE, personal communication, November 9, 2020).

Legalization, specifically, was recognized by participants for its ability to reduce organized crime associated with drug use. Family member John Hedican shows such crime as fuelling the drug poisoning crisis, and positions legalization as a logical response.

I think we need to remove organized crime....Drugs and alcohol are part of life. We need to change how we view that, and how we support it. And we have to talk about the source that is killing thousands and preying on the most vulnerable in our society. And it's organised crime. (J. Hedican, personal communication, July 14, 2020).

A similar view is echoed by Dr. Kindy:

> **The criminal element... people that are making the money out of that, don't have addiction issues.... they're living the high life, versus the poor people, you know, just dealing on the streets. I mean, they have substance use issues themselves, and end up in jail with a criminal record, they can't find jobs. And so we perpetuate this kind of circle of addiction.**
>
> **(Dr. Kindy, personal communication, September 9, 2020)**

Photo by: Daryll

By legalizing personal drug use, organized crime is essentially 'cut out' of the drug market equation, resulting in more equitable systems of treatment and care. Through this act, the 'circle of addiction' (which allows organized crime agents to benefit from the drug needs of people who are addicted, and often living in poverty), is broken.

This move to decriminalize, and going one step further, to legalize, was positioned by many as the most important action that could be taken in order to save lives:

You know, legalize everything, decriminalize. Provide clean dope, monitored, witnessed, whatever, but start saving lives. (Trigger, personal communication, March 18, 2019).

3.2.1.Summary

Amongst the participant group at-large, decriminalization (and legalization as an extension) was acknowledged as a viable response to the drug poisoning crisis. The act of decriminalizing drugs for personal use was associated with de-stigmatization, and the consequent enablement of people who normally hide their addiction to seek help. Legalization was touted as a way to reduce organized crime, and the kinds of injustices associated with the incarceration of poor people at higher rates than the wealthy. It was championed as a way to enact widespread shifts in our society's conception of people who use drugs.

3.3. Safe Supply

As with 'decriminalization' and 'legalization', 'safe supply' was acknowledged as a logical and necessary response to increased toxicity in the drug supply. As Dr. Wilson observes: "fentanyl in the system has been a game changer as far as killing people. So, clearly, a safe, clean drug supply is critical... without that... we're gonna be faced with ongoing deaths" (Dr. R. Wilson, Personal Communication, September 5, 2020). Not only was safe supply seen as important in keeping people alive, it was also acknowledged as a key factor in enabling people to stabilize their lives to the extent that they could seek treatment

You have got to have that safe supply first. And then once you got the people on the safe supply, then you can talk about weaning them down, getting into programs... It's a lot of effort of pounding the streets to come up with that 20 bucks, four or five times, or how many times a day. You know, it's a lot of work...and a lot of walking across town. From this side of town to that side of town, to this side of town to that side of town. And it takes up just all of your time (P. Sture, personal communication, June 30, 2021).

This stabilizing effect was seen to enable people to move beyond a perpetual search for supply, and into a viable treatment domain.

Photo by: Trigger

These comments summarize what many participants feel as a key benefit of safe supply – its ability to save lives by reducing the risk of toxic drug poisoning while at the same time stabilizing users – allowing them to move away from the often-relentless task of seeking drugs through street-based channels, and enabling them to seek help.

3.3.1. Safe Supply - Barriers

While safe supply was widely seen as a necessary agenda in combating rising drug poisoning rates, various participants expressed frustration with the pace at which safe supply is being unrolled in the Comox Valley, and at the hurdles they encountered in accessing it – as well as Opioid Agonist Therapy (OAT):

Sending someone on a wild goose chase, trying to get safe supply or speak with a psychiatrist, psychologist or something, is not good. That's what it feels like if you've ever walked somebody through that process, it's like a wild goose chase. You go from one building to the next and you end up just feeling, you know; you're like a cattle being shot through. It's

ridiculous. It's not effective, and I think that creates trauma in itself. (Anonymous outreach worker, personal communication, March 8, 2021)

Many of these barriers stem, according to an anonymous outreach worker, from the reluctance of local physicians to prescribe safe supply:

A lot of doctors here are really scared about just prescribing freely and so people still need to jump through a lot of hoops. There are a few cases that we've heard of that people are accessing safe supply, but it's not across the board. Not like in other places where people are really able to access safe supply, in a way that's easy, and with not a lot of barriers. But here, it's very tricky. (personal communication, March 8, 2021).

The feeling of ‘hoop-jumping’ was also echoed, it should be said, in relation to people attempting to access Opioid Agonist Therapy:

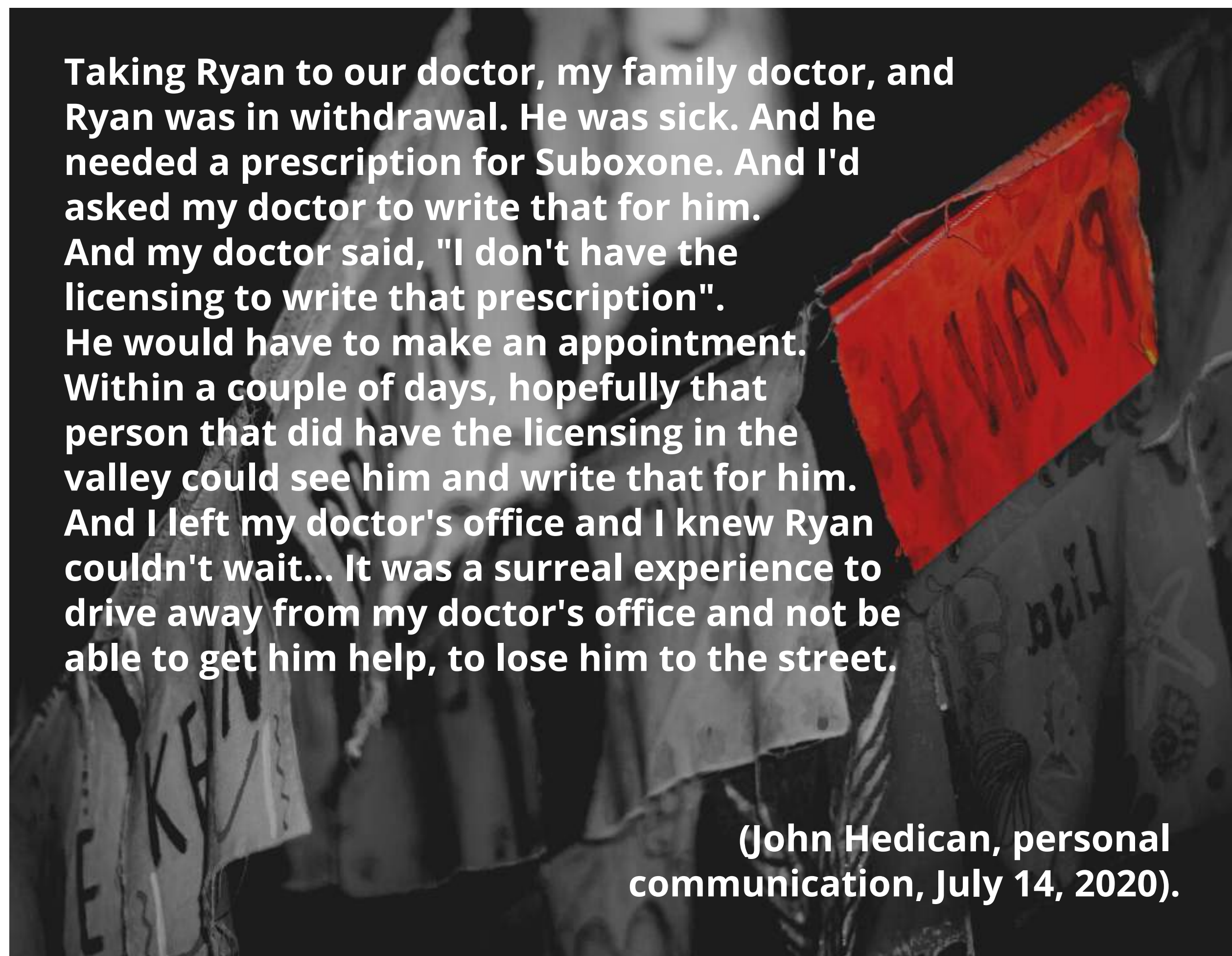


Photo by: Kyle Little

Similarly, a PWLLE speaks (in vivid detail) of the physical experience of withdrawal, and of the frustration she encountered when attempting to access OAT:

> **What they did when I came to the hospital, and I was five days off methadone, no, four days, four and a half days off methadone. And I said I had no way to get to my methadone, and I called them and told them "Hold my prescription. I will be there today". They did not. My doctor was away on vacation. Doctors in Campbell River, they only come here once every two weeks, sometimes once a month..... She therefore could not be reached. So my methadone script was kaput. And doctors as of now do not have the power to rewrite scripts. Only methadone doctors have that power. So I went to the hospital. I was withdrawing off of 80 milligrams of methadone. Severe withdrawal. Puking. Shitting. Shaking cold. It was horrible. My mom was scared. I was scared. They put me in emergency. I was in emergency for four and a half hours. I finally got in to see someone. They said "maybe we can give some Suboxone". The problem is if they put me on Suboxone, then I won't be able to get my methadone script back. And this was on a weekend, and then Monday was also holiday. So I might be able on Tuesdays, that was two days I'd have to wait two days to maybe get a methadone script (B. Mills, personal communication, March 18, 2019).**

These eye-opening accounts speak to both the difficulties people who use drugs face in accessing safe supply, and the barriers placed in front of people who are withdrawing from substances and need immediate access to Opioid Agonist Therapy. In both instances, the medical system is seen as slow to respond to people who need services, and in some cases as enacting systemic barriers for those seeking to 'stabilize' – a situation especially difficult for those withdrawing from drugs and in a state of physical and psychological duress.

While these accounts highlight the need for a more streamlined approach to the prescription of safe supply and OAT, it is worth showing the arguments made by physicians for caution with regards to the prescription of safe supply. Both Dr. Kindy and Dr. Hemmerich point to the history of opioid over-prescription by the medical establishment as cause for caution:

> **It started off with... methadone, that was all that was available. And there was oversight by the College [of Physicians and Surgeons of B.C.]. And maybe for about 10-15 years, prescriptions for pain became a big thing.... so a lot of physicians were prescribing opiates for pain. And some of these patients that were prescribed opiates for pain ended up being dependent on their prescriptions. And the College was overseeing the whole thing. And unfortunately, it wasn't the physicians or Big Pharma that actually came and said, "Hey, we're doing something that's not proper for patients, some patients are actually being harmed with these prescriptions". The College finally went, "Oh, maybe we're not doing the right thing". But their approach was completely wrong. So what the College of Physicians did is, basically... the patients that were getting prescriptions could no longer get prescriptions from their doctors, because the College came down on those doctors. So did the doctors do the right thing to start off with? You know, that's debatable, but at that point, the wrong thing to do was just to stop. And so what happened was people that had dependency on opiates went to the streets...so it magnified the problem.... so suddenly, we had people that had started with heroin. We had people that had prescriptions that ended up going to the streets, and were doing heroin.**
>
> **So now, fast forward to the last, let's say, few years... fentanyl came on. The College basically withdrew from the oversight. So there's no more College monitoring, which I think there's the good and the bad. Meaning that we have to remember that opiates, by themselves, are not safe. And with the nature of addiction, we have to have some monitoring. So if we start prescribing without monitoring, we cause harm... there's a push now to prescribe opiates without monitoring. And part of the issue with that is... you might be able to help a certain segment of the population but then also you're causing a lot of harm. (Dr. A. Kindy, personal communication, Sept 9, 2020).**

The key fear identified by Kindy in this account relates to the harm caused by an approach to prescribing that removes or diminishes oversight for both physicians (by the College) and patients (by their physicians). A similar fear is echoed by Dr. Hemmerich:

Well, I think most doctors are uncomfortable with that responsibility [provision of Safe Supply]...we're barely comfortable. We want to support, we'd rather them take it obviously, than buying carfentanil and overdosing. But yeah, doctors... we used to prescribe opioids, and we were part of the problem getting people addicted, because they were in chronic pain. And we thought nobody should be in pain, opiates take away pain. And then all of the sudden, the College said, 'you cannot prescribe this' and people just, you know, backed away and did not prescribe for their patients, they [patients] ended up using illicit street drugs because they were dependent..... To ask [physicians] to prescribe safe supply to somebody... who is actively using it just seems too dangerous, too risky. (Dr. E. Hemmerich, personal communication, August 13, 2020).

These candid views expressed by physicians provide a window into the rationales by which barriers to safe supply are being constructed, and by which participants are being systematically denied (or sent on a wild goose chase) in pursuit of this service.

To overcome these barriers requires, in Dr. Kindy's view, the development of systems of monitoring and oversight that are attached to safe supply:

I think what needs to happen is we need to set something up where there is monitoring. So it's not just, you know, safe injection sites, but it's also sites that provide medication for injection... You're going to be safer because it won't be contaminated. And if something happens, there's somebody there to help you. I'm totally for that. And if at some point you say, "you know what, I need help, I don't want the needle anymore"... Well, let's do this to help you. (Dr. A. Kindy, Personal Communication, September 9, 2020).

This view of safe supply as expressed by participant physicians, while acknowledging its role as a powerful life-saving strategy within the toxic drug crisis, calls for an approach to its enactment that also includes monitoring – of both physician prescribing and patient consumption practices.

3.3.2. Safe Supply Access

Additional issues, beyond physician hesitancy, were flagged by participants in relation to the roll-out of safe supply. Numerous family members and people with lived experience highlighted the fact that safe supply is available only to a subsection of the using population. Acknowledged here is the fact that a significant portion of people who use drugs do so casually, and are unlikely, given this reality, to access safe supply:

When I hear safe source, people are speaking to the chronic user.

They're not speaking to the adolescent 16 year old kid that's going to try for the first time. They're not speaking to the guy that hasn't seen his buddies, or the gal that hasn't seen her girlfriends. And they bring out a line of coke or whatever they bring out. And they're not speaking to the user that dies, like our son who relapsed, because they're never going to get a prescription. They're not going to do a safe injection site. So I struggle with that. (John Hedican, personal communication, July 14, 2020).

Furthermore, access to safe supply (as well as OAT) was seen as limited largely to opioid users – leaving a large segment of the drug using population underserved:

Heroin is the only substance that has another alternative like methadone. Cocaine doesn't have that, crack doesn't, all these other substances. So unless we address them all, we're not going to help us all. Right? How can we be honest with ourselves if we don't address everything, and everybody that needs support? . (Jennifer Hedican, personal communication, July 14, 2020).

This sentiment was echoed by Sam, who speaks from a personal standpoint about ineligibility for most forms of safe supply:

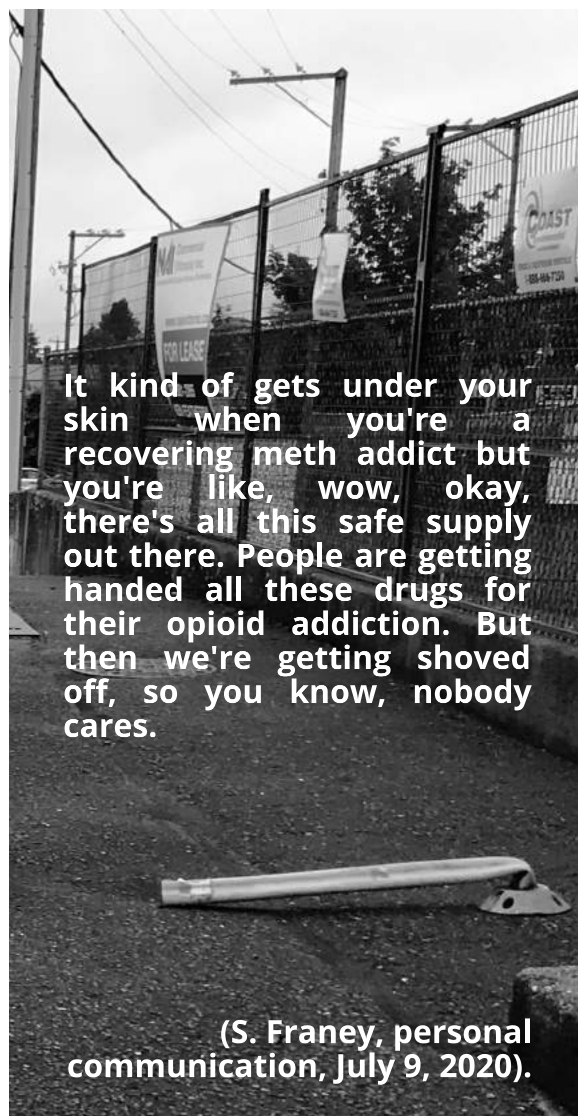


Photo by: Nadine Bariteau

While some physicians are, according to participants, starting to prescribe safe supply in response to addictions other than opioids (such as prescribing Dexedrine or Ritalin for Methamphetamine addiction), these prescribing practices are often

positioned on the ‘fringe’, rather than in the ‘mainstream’ of safe supply practice. People who use drugs other than opiates are often left ‘in the dark’ – unable to access safe supply.

These perspectives, considered as a group, bring to light a number of considerations to be made in the development and implementation of safe supply. They speak to the importance of structuring safe supply in such a way as to reduce the harm it causes through oversight and monitoring. They ask how safe supply/Opioid Agonist Therapy can be made accessible to more people – through increased licensing of physicians, the development of safe supply options for ‘casual’ users, and the development of prescription options for non-opioid users.

3.3.3. Summary

While safe supply was recognized by many interviewees as an important next-step in addressing the toxic drug supply, and while steps have been made by the provincial government to enable safe supply in the wake of the Covid-19 crisis, participants expressed a number of concerns surrounding the actualization of this concept. Work is needed to decrease the risk of harm caused by safe supply (through increased monitoring and oversight), and to make safe supply more accessible to people at different points of the drug-using spectrum.

3.4. Community Services (Downstream)

Up to this point, we’ve looked at the lived experience accounts emerging from participants in relation to the drug poisoning crisis as it is played out in the Valley, including at the stigma and racism participants encounter in their interactions with local support systems. We’ve also examined the views conveyed by participants in relation to the concepts of ‘decriminalization’, ‘legalization’ and ‘safe supply’ – interventions widely positioned as ‘solutions’ to the drug poisoning crisis. We’ve recognized a profound need for these interventions – also, however, the need to look closely at the mechanisms by which safe supply (in particular) is delivered so as to increase access, and enable its effectiveness through appropriate levels of monitoring and support.

Building on this discussion, the following section draws attention to a third tier of intervention designed to combat the drug poisoning crisis – identified by the term ‘downstream community services’. These are services that have a direct impact on people who use drugs and are geared specifically to work with addiction

Within this category, participant insights have been divided into two distinct sub-

categories: Harm Reduction Services - those that attempt to reduce harm and prevent drug poisoning for people who use drugs; and Recovery Services - those that attempt to support people in reducing or eliminating drug dependency. It should be acknowledged that these categories are distinguished from one another for analytical purposes; in practice, they are often interwoven with one another, and together comprise a spectrum of service.

3.4.1. Harm Reduction Services

Harm Reduction Services are those offering a 'first-line' defence against the risk of drug poisoning. In what follows, we journey through some of the key insights offered by participants in relation to these services.

Narcan

Narcan (also called Naloxone), a drug responsible for reversing drug poisonings, has been distributed throughout the province as part of a provincial strategy to combat the crisis; and is seen as an important front-line strategy by many within the using community. Participants with lived experience provided numerous, often-harrowing and at the same time amazing, accounts in which Narcan had saved their lives.

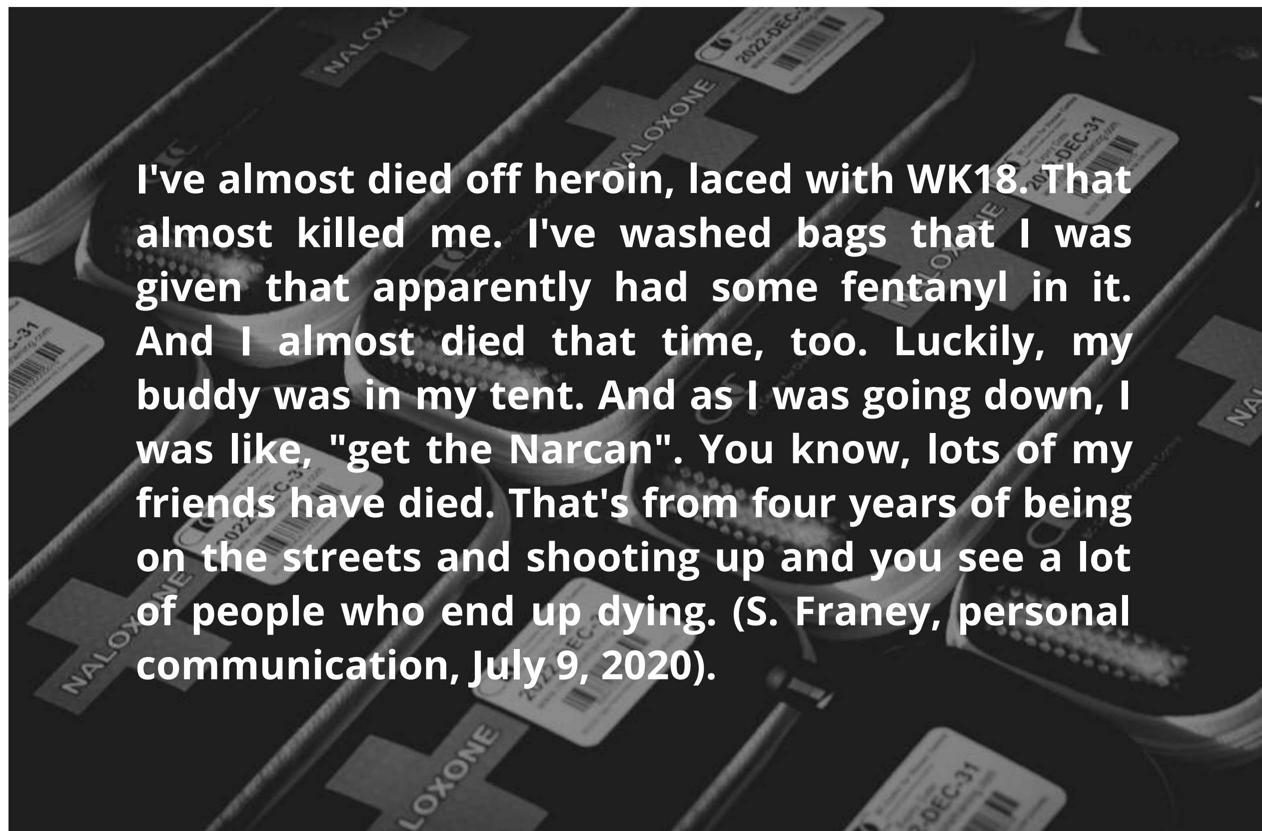


Photo by: Kyle Little

While Narcan as a drug poisoning response strategy was recognized as a key life-saving intervention, many participants cautioned against a reliance on Narcan as a singular solution. Narcan was recognized, for instance, as limited in its capacity to address an increasingly complex spectrum of toxicity as incurred through the mixing of substances. Additionally, it was recognized as limited in its ability to revive the 'whole' person after a drug poisoning. As Dr. Kindy (personal communication, September 9, 2020) states: "Once you've dropped, you've had a lack of oxygen. You've had a brain injury. Yeah, it's not like you get Narcan, you're back to normal". –While Narcan was seen by many as a key harm reduction pillar, many also cautioned against a commitment to Narcan as a singular solution.

Drug Poisoning Response Apps

Drug poisoning response apps were acknowledged by participants as providing an additional layer of protection. In the Valley, two distinct drug poisoning response apps have recently become available. The Lifeguard App, developed by the Lifeguard Digital Health and endorsed by Island health, allows people to signal, via the app, when they are using drugs. A countdown is started; when participants fail to signal responsiveness (via a 'button') prior to the completion of the countdown, emergency medical services (ie: ambulance/paramedics) are dispatched under the assumption that they are overdosing. The BE SAFE App, developed by a Vancouver Co-Op BRAVE, offers a Peer-designed digital drug poisoning prevention service. Users are monitored by phone agents responsible to trigger participant-developed safety plans should they become non-responsive. This system is seen to provide people who use alone with an additional layer of supports:

One of the major reasons why people are dying, is because they use alone. That is the main reason. That's why phone apps like Brave, will be very helpful and more effective than apps which have been previously invented. Because it allows for the community members to also connect, and play an important part in a life-threatening situation. You know, with the Brave App, we no longer have to depend on the first response, which takes 15-20 minutes in the Comox Valley, as some people could get to the scene in only 5-10 minutes (D. Bryzgalski, personal communication, March 8, 2020).

These apps were acknowledged by some participants to provide an important layer of protection – especially for people who are not able or willing to use drugs with others.

Drug Testing

Yet another layer of protection was identified by participants in drug testing. Currently available in the Valley, through

local outreach agencies, are test strips that indicate the presence of fentanyl, carfentanil and benzodiazepines. While these strips were seen as an improvement over nothing, they were also seen to harbour significant limitations – namely, in the fact that they only test for the 'existence' of these substances (ie: yes or no), and not for 'quantity'; also in the fact that they do not test for other harmful substances beyond the ones mentioned. The need for comprehensive drug testing (through, for instance, a mass spectrometer – a testing mechanism that produces a rigorous assessment of drug composition) was flagged by an anonymous outreach worker:

It's a little extra ask, that it be full spectrum testing. Because the types of strips that we have, and the OPS have are just fentanyl or carfentanil or not. So we test dope when people come in, but it only indicates that tiny group. So with full spectrum testing, a person can bring their stuff in and see exactly what it is. And it's just a money thing, like there's no funding or whatnot for it. And those strips that we carry, and we will test - it's like yes or no, but it's not really telling somebody what else it could be. So yeah, I feel that's a really crucial part of the testing. (personal communication, March 5, 2020).

The advantages of full-spectrum testing were acknowledged by multiple participants with lived experience:

Not only is it [full spectrum testing] going to save individual lives, but people are going to start figuring out like, who constantly has an inventory full of stuff that's tainted with things that they didn't warn you about or tell you about (E. Mayoh, personal communication, October 11, 2019).

While the cost of full spectrum testing equipment has been seen as prohibitive in some small and rural communities, the purchase of such equipment for the Comox Valley was recognized as a key pathway forward in reducing drug poisoning deaths. PWLLE Dawid Bryzgalski shows speaks to the new-found need for such testing in an era of toxic supply:

From my experience, in 20+ years of using, we had never heard of "drug testers". I mean sure, they were available and used by doctors and staff at detox, rehab and other clinics, but never for use or dispensed amongst patients. Back then everyone was dropping dead from the purity of the heroin, but now people are dying because of the toxicity in the "street dope", they really haven't got a clue as to exactly what they are shooting into their veins today.' (personal communication, March 8, 2020).

According to Bryzgalski, the failure to implement a comprehensive testing system spells disaster:

If this crisis keeps progressing, is here to stay, and we don't provide our children and youths' in our community with "drug testers", "clean dope", and plenty of great safe injection sites, then we're basically sending them to a "death drop". As one day the "street dope"

will be spiked a little bit too much, and they will "drop", as many, many of my friends died, some in my very presence' (D. Bryzgalski, personal communication, March 8, 2020).

Here, then, we see emerge a call for more comprehensive testing strategies to be implemented; and an acknowledgement of full-spectrum testing, in particular, as an important 'layer' of protection in the wake of rising drug poisoning numbers.

Harm Reduction Service Providers

Participants across the board acknowledged the role of drug poisoning Prevention Sites generally, and the OPS site formerly hosted by AVI (currently hosted by Island Health), in stemming drug poisoning deaths, and in connecting people who use drugs to 'wraparound' services. Participants expressed a desire for more OPS services dispersed throughout the Valley, and for an extension of OPS hours and services:

I love AVI, AVI's a great place, people are great. I think we need those services here. I think it would be great to have an [OPS] tent or, maybe a bus or something. I think to maybe make those hours longer, or put something in on another side of town. Because for a lot of people, they live in different places all over the Valley and to get those harm reduction supplies is hard. I know for me, I live all the way up on Mission Hill. Sometimes if my dealer's over there, I use the same fucking syringe four times in a day because I can't get over here. That's not good. I can't be doing that.... I know [there's a number I can call for mobile service] but sometimes it's after hours or whatever, right? I'm just saying, things to think about right? But I love AVI, it's a great place. (B. Mills, personal communication, March 18, 2019).

Additionally, numerous participants advocated for an extension of AVI's capacity to witness different forms of drug use (other than injection and snorting), including smoking: "You can use AVI but a lot of people can't smoke in there and stuff like that" (Trigger, personal communication, March 18, 2020).

Across the board, AVI was seen as a place where drug users were well-served, and where vital forms of harm reduction were delivered in a compassionate and non-judgemental way. At the time of the interviews, the AVI overdose prevention site was being transitioned to Island Health – a move seen critically by the many participants.

They're threatening to close our OPS in the middle of a crisis, because our numbers aren't great. Numbers vs. people's lives... how many people have to die before we make lasting change? (D. Grimstad, personal communication, June 12, 2019).

Similar sentiments were echoed by Dr Kindy and Dr. Hemmerich:

Well, I personally think that's a tragedy that that safe injection site was closed. Because AVI provides that wraparound service, right? So they provide more than just a safe injection site. There's a place that you can go talk, that you can go get help, that if you need your paperwork done, people will help you, you've got a listening ear. So I don't see the logic of that at all. Like it's beyond me why they would have done that. I think AVI's shown themselves over the years, you know, I hugely admire AVI as an organization. ... So I think to close something that is known to work. I don't see the rationale there in a time of crisis, it makes no sense. (Dr. A. Kindy, personal communication, Sept 9, 2020).

AIDS Vancouver Island [now called AVI Health & Community Services] has done an amazing job, and what they did with the OPS and connecting with people, supporting them, and harm reduction supplies. So I think it's a loss. It's a big loss. And where people felt quite accepted and very much at home. So there's big boots to fill, for the new site, but hopefully they'll be able to adjust and make it a similar place. I think the key too is people need to feel comfortable, and trusting. But also we'd need long hours. It has to be, you know, man powered. But still, it's such a small window, really. But it's going to be I think, seven days a week. So that's a start. (Dr. Hemmerich, personal communication, August 13, 2020).

Acknowledging these sentiments, it is important to also acknowledge the continued grassroots work being done by non-profits including (but not limited to) AVI, in supporting people at the heart of this crisis. Outreach Worker Galen Rigter points to the 'invisibility' of this work, and to the fact that it is rarely acknowledged:

The work non-profits are doing... it's incredible. A lot of it will never be seen by the public - [yet] I can only imagine what this world would look like without the amazing work these agencies are doing (personal communication, August 12, 2021).

The effectiveness of this work relies, according to numerous outreach workers, on the ability of grassroots organizations to put in-place staff who identify deeply with the Lived Experience community. Del Grimstad (outreach worker) says: "When we're going out into the using community to try to make an effective change, we really have to make sure we're putting people in-place that understand the community" (D. Grimstad, personal communication, June 12, 2019). Here we find a recognition that many people engaged in active drug use struggle to engage with, and feel safe within, traditional clinical environments, and are more able to accept services delivered through 'grassroots' channels. Additionally, we find a call to provide people who use drugs with wrap-around levels of service simultaneously, and for service that 'meets users where they are".

Coupled with this acknowledgement of AVI's 'grassroots' role is a recognition by

participants of the importance of other harm reduction services in the Valley, including the Health Connections Clinic / Nursing Centre, the Mobile Outreach Unit (formerly operated by AVI, a program that has since been terminated), the Care-a-Van outreach station, and Unbroken Chain – Indigenous Harm Reduction program for the community. Many participants made it clear that these services play an important role in their own personal landscapes, and in a larger harm reduction ecology.

Peer-Led Interventions

Perhaps more notable, even, than the grassroots work of local non-profits, is the work , being accomplished day in and day out by PWLLE - as individuals band together formally and informally to create their own harm-reduction platforms. Outreach Worker Galen Rigter speaks to the importance of these initiatives. While on one hand he sees the Valley's 'formal' Peer-support infrastructure overall as lagging behind those in place in many of the larger urban centres such as Victoria and Vancouver, recent initiatives have kindled his hope that this infrastructure is being developed:

There are some great things happening [in the Valley] currently... [Peers are] out there, getting grants to start their own groups. And when I meet with them, and AVI does our best to support them with equipment and training, they speak to how amazing it feels to give back, to get some new skills, and then to help share those with people... (personal communication, August 14, 2021).

The power of the community's peer support infrastructure is found, it should be said, not only in its ability to enable PWLLE first responders to save lives and reduce harm, but also, in its ability to bring a sense of purpose and pride to those doing this work. Peers supported in their grassroots outreach efforts often, according to Rigter, take great pride in the role they play in mitigating the crisis. The fact that a support network (for the Peer support network) is in place, through such organizations as AVI and the Community Action Team, demonstrates solidarity, and further contributes to a sense of meaning and pride:

It's super empowering. I can physically see a shift in people's swagger.... they're standing upright, they're proud of what they're doing, they're sharing it, the public is behind them. It's great that there's the Community Action Team in town supporting them, offering them what they need (Personal Communication, August 12, 2021).

Aside from supported peer interventions, many PWLE are doing this work independently, or 'under the table'. Jo, for instance, speaks to a 'pop-up' safe injection site that has, from time to time, been informally organized by Peers in the Valley:

We were really getting somewhere with the group that we had going. We had people coming to us. I had people. I live just a little bit out of town and on a weekend I could have up to 15 people show up for different various things. Getting the safe injection sites up is our number one thing I think in the Comox Valley…. If somebody does go down, and we can revive them and send them home, in a good position and stuff, they'll get to trust us (J. Moore, personal communication, March 18, 2019).

Such a site allows PWLLE to transmit to other life-saving information and support:

It sounds condescending, but such simple things about, you know, how to clean your spoon in between usages and stuff. And this one girl says "Oh, I don't clean mine, because it's a build up on this. So I get more and more". And I'm going oh, my god, no, no, no, no, no, you know, and so I showed her the whole scenario of it. I said, "It only takes two extra seconds". "Yeah, but I could get it in me". No, you could kill yourself by doing that, too. But it's the knowledge, right? Get the paperwork out there, get the fliers out there. Talk to the people, you know, go to the tent places. You know, have a couple safe people that could go into the tent cities and be welcomed, right, you know, not go in forceful, or whatever. But be part of the group, and go in and say "Hey, I can bring supplies three times a week. I'll bring in supplies, I'll pick up supplies". We've got people out there that are doing this, but we need more, you know, we need more. (J. Moore, personal communication, March 18 2019).

Here we see a powerful role being assumed by PWLLE in informally organizing and manifesting interventions that impart direct support to those at the heart of this crisis. The importance of such initiatives cannot, according to Rigter, be overstated:

It keeps me up at night to think about what the number of deaths would be if it weren't for what People with Lived Experience / Living Experience are doing on the streets everyday – countless accounts of folks coming to us saying how many people they've saved by administering Narcan or rescue breaths, that kind of thing – the numbers are staggering. And I think that a lot of this stuff is unseen by the general public. There's a whole family of folks out there who are taking care of eachother and they've been doing this forever. And I just feel like they have not been given a platform to either let people know what's happening out on the street, or haven't been given the credit they deserve. (Personal communication, Aug 12, 2021).

These comments speak to the important role peer outreach is playing in the crisis locally, and to the potential for mobilizing peer agency and leadership in the quest for solutions.

Fragility in Harm Reduction Services

While these front-line services were acknowledged as important to the Valley's harm reduction efforts, they were also seen, in the view of several outreach workers, to be fragile; at-risk of

being defunded, or discontinued. Outreach worker Galen speaks to a dramatic reduction in funding for these 'front-line' harm reduction services that has, in his view, occurred recently:

I've only been in the valley for two years, so I'm still finding my way, but in those two years I've been here, seeing the drastic funding cuts to agencies who are essentially front-line, essential service programs, is horrific and terrible... that there's been a dollar amount placed on numbers of people coming through a door or using a service, it's completely unethical and immoral. (G. Rigter, personal communication, November 20, 2020).

It is important to note that while some key programs, such as AVI's mobile outreach unit, have been cut, new programs, such as the Foundry (youth-based harm reduction) and ACT (mobile harm reduction) have been recently introduced. Work is needed to conduct a comprehensive assessment of programs/services in the Valley, with an aim to identify key service gaps.

Across the board, the front-line harm reduction services being offered by such agencies as AVI Health and Community Services, the Nursing Centre and Care-a-van, as well as the services being offered informally by the PWLE community, were seen to play an important role in preventing drug poisoning deaths, and in providing culturally safe services to people who use drugs in the Comox Valley. The expansion of these services, including expansion of the types of witnessed consumption offered, of operating hours, and of services into other areas of town, was seen as a priority. Furthermore, the continued development of 'alternative' and/or 'grassroots' models of harm reduction, including peer-led models, was seen as a priority, in that these models were seen to make harm reduction more accessible to the using community.

Summary

Within this section, we've examined participant conceptions of the 'layers' of downstream services referenced by participants within the Comox Valley – ranging from Narcan distribution to drug poisoning response apps to drug testing to harm reduction programs delivered by service providers. Across the board, participants spoke strongly of the need for services that meet them 'where they are'... services that acknowledge the tension many drug users have in navigating clinical settings and medical systems, and that provide alternative stigma-free spaces in which users are connected with multi-layered supports (including supports for mind, body and spirit) in a non-judgemental way.

3.4.2. Recovery Services & Supports

Beyond harm reduction services and supports, participants offered numerous insights related to recovery services and supports.

Detox

A consensus emerged from participants throughout the project related to the need for more comprehensive detox, treatment and sober living services in the Valley. Here it is important to acknowledge the distinction between medical detox, which involves intervention by qualified medical professionals and is often accomplished in a short time-span; and social detox, which involves a live-in sober living situation for a period of weeks or months coupled with social services and supports. Medical detox is often a precondition for entry into social detox facilities. Two facilities were acknowledged by participants to provide social detox services in the Valley - The Recovery Centre for men and Amethyst House for women. While the hospital was seen to, in certain circumstances, provide medical detox, this option was often seen as limited. The closest medical detox centre was identified by participants as Clearview Community Medical Detox centre in Nanaimo.

Before addressing the recommendations surrounding detox services put forward by participants, it is important to show how traumatic, from a lived experience perspective, the denial of access to detox and rehabilitation services can be.

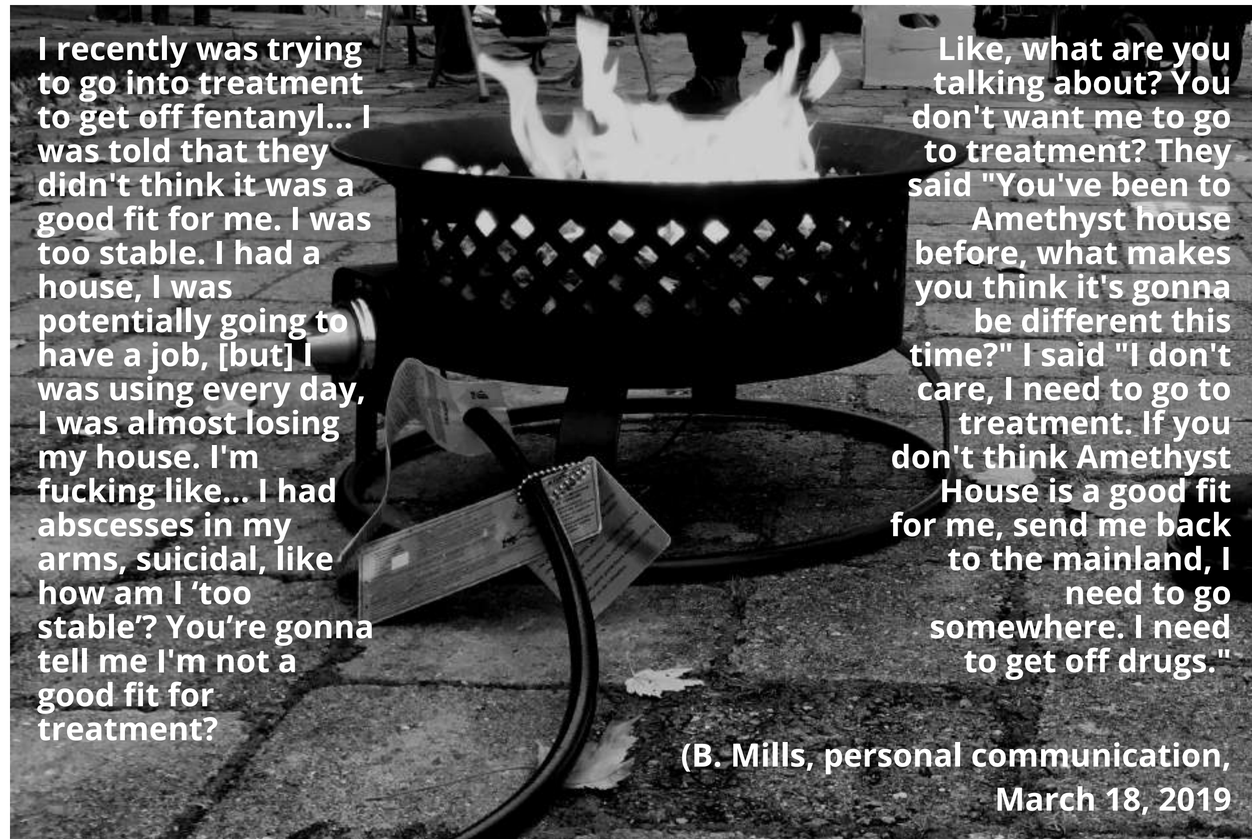


Photo by: Nadine Bariteau

These words ring powerfully; they give a sense of the desperation and anxiety faced by many who have made a decision to come off drugs and are not able to access the appropriate detox services.

Within the Comox Valley, participants identified the absence of medical detox service, as well as a limited number of social detox beds, as a key gap. The slow response time for participants to gain entry to medical (in Nanaimo) and social detox facilities was seen to contribute to this Gap: “we need more treatment, recovery beds for sure. And ideally, a medical detox centre” (Dr. Hemmerich, personal communication, August 13, 2020). Similarly, Dr. Kindy states: “we need to have a way of dealing with addiction where, if there's an opportunity, there's a bed” (Dr. Kindy, personal communication, September 9 2020). An anonymous outreach worker reinforces this same argument: “If we can't get together and find a detox bed and get somebody in the moment doing that, that seems like a major gap in this community” (Personal communication, March 5, 2020), And again, outreach worker Bryan McNicol echoes the this call for immediacy in detox services

It can be two or three weeks, sometimes longer [to access a detox bed]. Yeah, sometimes longer, quite a bit.... You know, it's medical detox these guys need, and we don't have it.. there's such a small window of opportunity with addicts, that they have a brief moment of lucidity, where they go, "I'm done". But you know, give it an hour. Now, maybe not. And that's sad (B. McNicol, personal communication, December 13, 2019).

This call, made by physicians and outreach workers alike for the enablement of quick access to detox services, was echoed by numerous people with lived experience:

People trying to access detox, to get [a detox bed], have to jump through hoops, or know the right person that can get them in, who's going to get them in quicker. And for someone who needs it right then when they're ready, when they're ready that day, it comes down to hours. If they don't get in, you know, in those hours, something could change for them in the next few hours, where they may decide that they don't want to. And if the doors keep going up in their face, the less likely they are to keep trying to go into a detox, and just give up. (S. Katsanikakis, personal communication, December 17, 2020).

Not only are detox services required that are quick to access; but also, services that have, at their core, a commitment to the rights and empowerment of drug users:

Jo: Going to treatment. I found you lose your dignity when you're there.

Anonymous: They make you sign a piece of paper to take your rights away. So everybody gets to do whatever they feel like. You have no choice but to go through..

Jo: ...their system. We didn't get to be where we are at our age without being resilient... Why can't the system allow Miles to do it [detox] the way he wants to do it? He's determined. But there's society going "Oh no, that wouldn't be a safe thing to do". And meanwhile he's dying in front of us. (J. Moore, Anonymous, personal communication, March 18, 2019).

Here, then, we see identified a desperate situation, in which people who have made a decision to come off of drugs are faced with an astounding set of barriers – including lengthy wait times, the need to access services out-of-town, and a lack of fluidity between various detox systems. Some who are able to access detox critique it for its lack of dignity and its propensity to strip people of their identity. In these words lies a strong call to action – for an increase in detox services, a re-formation of detox to better-serve drug user needs (ensuring fundamental respect and dignity), a decrease in wait times, and an effort to better-coordinate services.

Subsidiary Services

While detox services proved a 'hot-button' item amongst participants, it should be noted that conversations around detox were linked with conversations also calling for a range of subsidiary supports – from sobering centres (pre-detox) to sober living centres and culturally-informed aftercare (post-detox).

If they had sobering centres, where they could be safe until they could get in [to detox] and graduate into medical detox if they need it. And then work into some kind of treatment thing, whatever it is. I think they need more treatment beds. But they also, like, we get guys that have been through there four or five times, sometimes more. Some guys have been to like 29 or 30 treatment centres. The big reason that doesn't work, there's no safe place when they get out....Because we tell them to change your playpen, playmates, and then, well, okay, that's great. Where's my new playpen? How do I get away from my playmates? Well, you're gonna gravitate to the things you know, and that's a problem. So it's a big deal. But I mean, if you did it four beds at a time, right? Or eight beds at a time in the valley. .. (B. McNicol, personal communication, December 13, 2019).

This call for a comprehensive spectrum of services surrounding detox is echoed by participants with lived experience and outreach workers alike:

When you come out of that [detox], often times you come out onto the street. Most times that you come out of that, they send you back to the hometown that you came from. So you're coming back onto the street with like 20 bucks in your pocket, or 100 bucks in your pocket which is just enough to buy some drugs... you know, and you're back on the streets with the same old people. So I think a lot of those things fail by not having aftercare....Yeah, you know, sufficient aftercare or plans in place. (Anonymous, June 30, 2021)

An anonymous outreach worker echoes this same sentiment:

There needs to be a variety of aftercare options provided. There's many pathways to recovery. What might work for one person may not be what another person wants to do. Maybe somebody wants to learn their culture and their ceremonies and practice. That needs to be offered to people, not just "here, here, take this card and call this number". We know it needs to be culturally competent when you do the aftercare. It has to be evaluated and assessed thoroughly, not just "okay, let's fill this paperwork out and get you out the door" (personal communication, March 8, 2021).

Another anonymous outreach worker adds to this call for comprehensive aftercare – speaking specifically to the need for sober living. When asked to speak to the needs she sees as most pressing in relation to the Valley's service infrastructure, she outlines a spectrum:

Detox and also sober living, or different stages of housing for people on the other end. And again, not with the expectation that people need to clean up, or get a certain life going. But what about those who we're hearing over and over do want to see that change? This crisis has scared the shit out of them. They're burying all their friends and family and they want out. But we don't always have that moment. (Personal communication, October 14, 2020)

And Dr. Hemmerich speaks to the need for programs that allow participants to form new relationships, and engage in low-barrier employment:

Having a life for people as they go through recovery where they have supportive housing, assisted living to allow them to return to a more healthy normal life, with work/job opportunities… working on farms… low-barrier employment where they can start to recreate their life. Teaching… life skills… a big piece is creating new relationships with people who are not using. You're breaking your bonds, which is huge. (E. Hemmerich, personal communication, August 13, 2020).

Flagged here is the need for a comprehensive, inter-connected chain of services that has capacity to respond quickly (ie: within the same day, often) to the medical and social detox needs of clients, that enables long-term growth and development, and has the ability to meet clients 'where they are' in terms of aftercare. Such a chain would provide a comprehensive, and long-term strategy in place of what now appears as a piecemeal approach to detox and treatment services, and to recovery services at-large – an approach that leaves people seeking treatment vulnerable to gaps in care.

Coordination of Services

Beyond this concern with better-coordination of detox services, the need to better-coordinate harm reduction and recovery services at-large was seen as essential for a reduction in deaths in the Valley. As Megan

Lawrence (outreach worker) observes: “We just cannot seem to get a coherent consensus on moving forward together. It's still very much... our community is fractured, even in the approach of how to support people” (M. Lawrence, personal communication, December 13, 2019). An anonymous outreach worker echoes this same sentiment, and calls for the reconfiguration of services such that they are integrated, and working together fluently: “I’d love to see us all get together and do a better job of having a hub-type environment” (personal communication, March 5, 2020)... This notion of a hub; of a ‘coordinated togetherness’ is also put forward by Bryan McNicol (outreach worker) who believes it would lead to substantial improvement in the way in which the drug poisoning crisis is addressed in the Valley.

The people who are in the business model, they're looking for cost effectiveness. I understand that, I get that, it bothers me, but I get it. But if they saw that it was really making a change, and if we could get it together more than we are, they'll start saying, yeah, this is working. Because what they have to go on right now is, well, that didn't work. (B. McNicol, personal communication, December 13, 2019).

A similar call is made by Anonymous family member, who speaks to the disjointed landscape of care in which her daughter’s calls for help were positioned – a landscape characterized by broken uncoordinated systems. She calls for bold leadership, and for bold imagination in the coordination of a new care paradigm:

Brooke and I had almost every kind of help you could access. I accessed everything. ....But there was no follow up, and no real support for me or her. I... I have been in despair for years...the medical system’s broken.... The justice system is very broken. And like I said, I didn't know what in the world you would be able to offer or do. Because it just seemed like there's no one listening. There's no one driving the fucking bus. ... It's the lack of imagination that I am sick of. I'm sick of it....Especially the lack of imagination, and the lack of courage (L. Hynes, personal communication, June 11, 2020).

While the coordination of services, and the filling of service gaps, might be dismissed by funders and policy makers [working with a business model] as ‘too expensive’, it is put forward by outreach workers, physicians and PWLLE alike as a solution that would ‘actually work’ – a solution that would allow people who use drugs to engage with a comprehensive, coordinated and individual-centred system of sobering, detox, treatment, sober living and aftercare. By investing in such a hub, the Valley would, according to numerous participants, achieve a sustained shift for people who use drugs, and dramatically improve their prospects for health and long-term wellbeing.

Community Integration

One final gap identified by outreach workers in relation to the current harm reduction and recovery systems in the Valley, pertains to the need for 'community integration' spaces for people who use drugs. These are spaces where people who use drugs, and/or people in recovery, are enabled to gather together and with the wider community - cultivating connections, belonging and purpose. Such spaces should, according to an anonymous outreach worker, be hosted by people who understand the concept of 'meeting people where they are', as demonstrated by the work of AVI and Unbroken Chain:

I think AVI and Unbroken Chain do a pretty good job of holding space for people. I think that's what you have to do, is to create a safe space for people so that when they are ready, they will come back. Just having that support and the staff there that are willing to take the time with somebody, and just spend that time unconditionally. Not having an agenda, just being there for them. I think that's a good model, to create safe spaces where people can go and feel welcome. And they're not judged, and they're not treated badly. (personal communication, March 8, 2021).

A similar call is put forward by Galen (outreach worker), who calls for programs where PWLLE can gather and be supported:

Having more social programming where people can get together, that sense of community and belonging... which is what everyone needs to be well is that belonging and acceptance. More programs that are inclusive for folks, and these don't have to be incredibly elaborate programs. They can be as simple as a drawing group, a walking group, a weekly picnic. Getting folks together and saying 'you matter, you're worth something, and you're supported... you're cared for by the community' (G. Rigter, personal communication, March 18, 2019).

The work of AVI and Unbroken Chain provides, perhaps, a model by which such spaces might be developed throughout the Valley, and integrated into a central hub and network.

Summary

In this section, we've examined participant comments in relation to recovery-based services in the Valley, including at the need expressed for more immediate and considered detox services (especially medical detox), and for a wide range of pre- and post-detox services that consider the unique needs of drug users, and that allow for the development of new connections, new relationships and new forms of community contribution. The model being advocated by participants at-large is a holistic one, wherein the multiple pieces of the recovery services and harm reduction landscape are brought

together – the strength of this connection contributing to an overall improvement in the effectiveness of each individual program, and of the system at-large.

3.5. Social Determinants of Health (Upstream)

Tied into these downstream services are social determinant-based ‘upstream’ services acknowledged by participants as having a powerful role in improving the state of the crisis in the Valley. In what follows, I summarize participant insights in relation to three key ‘upstream’ service areas: housing, mental health and education. It should be noted that these areas constitute a non-definitive list; additional work is needed to analyze the full spectrum of upstream services, and social determinants of health, and assess their impact on the crisis.

3.5.1. Housing

References to the importance of housing emerged frequently through the research sessions. The fact that housing costs have skyrocketed in recent years, leaving numerous people on the low- and mid- income spectrum without any viable ‘place to be’, is seen by many to have exacerbated the drug poisoning crisis. Dr. Kindy summarizes this situation, and points to links between housing and Substance Use Disorder:

I can't understand how people can even live in the Comox Valley area anymore. And when I look at the cost of a month of rent, you know, with people's income, it's impossible. And I think that's a huge crisis. That's a huge crisis. And if you have substance use disorder, how can you get better without a roof over your head? I mean, it's impossible. That's basic, you know, food, lodging. So if we can't provide lodging, how are you going to get better? You can go to detox treatment, but then what happens when you come back if you don't have a roof over your head? (Dr. A. Kindy, personal communication, September 9, 2021).

Beyond bricks and mortar notions of housing, various participants advocated for places to camp:

> **In terms of services we're completely lacking anywhere that people can camp reliably without being harassed. Like as long as you can keep it safe and clean then there should be somewhere, anywhere. Preferably like three different locations so that if certain groups don't get along with others, you know, they don't have to be side by side with drama and create some sort of drama vortex and then the whole idea goes down the toilet, it'll turn ugly. And we're not talking about any permanent structures, it'll still be camping. Like there won't be a shanty town building. It's clean, it's not permanent, and it's safe. If you've got a problem with any of these things don't stay here. But otherwise it should be there. Somewhere to go, somewhere to camp while you figure things out. So you don't have to haul around all your shit and you can't go in anywhere without fear of somebody walking off with your stuff. (E. Mayoh, personal communication, October 11, 2019).**

Such places, it was noted, should be located within walking distance to the services accessed by people who use drugs: "There's a number of services within five blocks" (Anonymous outreach worker, November 5, 2019); "if you've got a cluster of services, why are you systematically displacing people further and further away from the services that they need" (E. Mayoh, personal communication, October 11, 2019).

An innovative response to this housing crisis emerged from discussions with Sam Franey, a participant with lived experience with both substance use and homelessness. Sam speaks to a peer-led housing initiative he's in the process of developing:

> **I've just started a non-profit called Comox Valley Unhoused Society. It's about rehabilitating and housing people on the streets and people with mental health and addiction issues...Yeah, the society is to rehabilitate and house people on the streets, especially ones that struggle with mental health and addiction issues. (S. Franey, personal communication, July 9, 2020).**

This initiative, involving the creation of a tiny home community, is one that has been developed through grassroots engagement with the lived experience community: "It comes from four and a half years on the streets, talking to people that need it, and putting together something from their perspective. It's 100% from the voices

that need it to happen for them" (S. Franey, personal communication, July 9, 2020). The concept provides people in recovery with the necessary tools and support to build their own tiny home community, and provides a range of recovery-based supports tailored to meet their individual needs.

Here, then, we see an acknowledgement of the important role housing plays in recovery and harm reduction, a recognition of the dire state of housing affordability in the province and valley, and a grassroots, community-informed solution posed by someone who has lived unhoused for many years.

Mental Health

Numerous participants spoke, as well, to the need for stronger mental health support (generally) as a means to address the drug poisoning crisis. The link between mental health and addiction constituted a continuously emerging theme, with many flagging mental health issues as the core reason for their addiction:

> **My addiction really started when I was 17. And I started to struggle with some mental health issues that I didn't know how to cope with. They weren't anything I had ever experienced before. And my family tried to help by, you know, sending me to psychiatrists and doctors and stuff. But I couldn't handle the pace at which I was, I guess, recovering from that, or dealing with that. And so I turned to drugs. It started with MDMA. And for me, it was like, the first time I used, it was a lot. And I didn't stop, like the next day I use the same amount. And the next day, and the next day, and I didn't...I stayed high. Like, I never really spent any time clean once I started using. And a few months later it progressed to Cocaine. And then Ketamine, and Meth was all mixed in there and stuff just kind of snowballed....I didn't really spend much time sober at all. And that was mostly because when I did stop using I couldn't handle what was going on in my head. And so drugs were really just like a medication, like a solution. It was like my way to feel okay and function in the world. (S. Katsanikakis, personal communication, December 17, 2020).**

Sophia’s acknowledgement of the link between drug use and mental health crises was articulated by numerous other participants. Judy Johnson family member speaks to the interconnectedness of these concepts: “Addiction is a part of mental health. And everybody who is addicted has a mental health problem. It's a mental health issue, and that's what we need to address. Just stopping the drug doesn't stop the mental illness”” (personal communication, June 11, 2020).

Similarly, an anonymous PWLLE shows how efforts to improve mental health care have a direct impact on the drug poisoning crisis:

We condemn and stigmatize mental health just like we do addiction.So I think the two are very common, they usually go together. I think if we don't learn to help people cope and provide different treatments, and really invest in mental health support and PTSD recovery, and a lot of things like that, and let people feel like they're supported and that there's not something wrong with them... that's a big part of addressing the overdose crisis. (personal communication, March 8, 2020).

Recognizing the broad call expressed by numerous participants for improved mental health support, a family member speaks specifically to the need for improved monitoring and follow-up within the mental health system, observing the current levels of care and support as inadequate:

I've been involved, heavy with my daughter since she was four years old, when she was diagnosed with all of her stress disorders. And I've dealt with massive counsellors, psych doctors, detox centres, more psych doctors. And I really don't know the answer, because it's not working. And it never worked for [anonymous daughter], at all. And she had more hope given to her, and I worked alongside her, with her, on every one of these things. I was her arm, and there's a lot of information, but it's not going anywhere. And it makes me upset too, that we're heavily prescribing drugs for people with mental illness.... So you have somebody who has mental illness, and they put them on drugs. And then they find a way to self medicate on drugs. And there's nobody following and tracking these kids at all....There is no one really caring for mental health people. That's the issue.... there was no follow up, and no real care. And that makes me really upset because if you want to talk about behaviour modification, and all counselling, and what they said to do, and what I tried to do, all my life with her, it never worked. (L. Hynes, personal communication, June 11, 2020).

These comments provide powerful insight into a key support system seen by many as broken. They speak to a need to re-examine care paradigms, such that those providing mental health care have the time and resources to develop more fulsome understandings of client situations, and more meaningful, long-term and regularized relationships leading to better care outcomes.

Education

A third key social determinant of health identified as having a strong relationship with the drug poisoning crisis is that of education. Judith Conway (family member), advocates for more to be done in schools to equip kids and youth with the tools to communicate with others their mental and physical needs – leading to stronger coping abilities and positive mental health and addiction outcomes. Speaking to the hurdles her son Matthew faced, Judith advocates for stronger, more in-depth teachings around communication, emotional awareness and social negotiation to be provided through the school system and other learning domains:

In describing Matthew's life, I often compare it to a leaky hot water tank. At first, we notice a few drops of water in the pan at the bottom of the tank. Then the drips begin to accumulate and we continue to wipe away the mess until one day the hot water tank bursts and the damage is done, not only to the tank but everything around it. What started as a small leak, turned into a huge, complex and expensive problem. If only we were just talking about faulty tanks. Instead of water damage, we are losing our children. Unless we start early when we see the first signs of a drip we will continue to lose an alarming number of young lives. Depression, anxiety, drug use and mental illness are at an all-time high. Many components, (the internet, stigma, shame, fear, lack of support) contribute to what is happening. I know communication is a key part of the problem and therefore must be a part of the solution. I believe if conversations around mental health are normalized at a young age, we can solve many issues before they become chronic with potentially deadly consequences. This proactive approach needs to be started in schools as early as kindergarten and straight through the teen years. Coping skills, identifying pain, understanding why we act out or why we are angry or frustrated needs to start at a young age. It's also important to identify the needs of self and others and effectively communicate those needs without shame or stigma. If we learn these skills early, we will live in a kinder, more compassionate world and people like my son, Matthew, and thousands of others might still be here today. (Personal communication, June 11, 2020).

Through Judith's words, we hear expressed a need to re-evaluate dominant education strategies, with an aim to better-support children and youth in coming to terms with conflict, mental health issues and difficult social dynamics, and in developing the skills needed to navigate an increasingly complicated world.

Primary school teacher Jen McFarlane agrees with this expressed need, and highlights a recent evolution in the B.C. curriculum that has, in her view, enabled some progress to be made in supporting kids in developing such coping mechanisms:

The BC curriculum has a new element called the core competencies, so we're not teaching content, we're teaching skills. And the idea is they're skills that a child can continue to build and grow throughout their whole time at school, and then use them throughout their life. And the skills are around the areas of creative thinking, critical thinking, communication. But the areas that I love teaching are around personal awareness, and social responsibility. And under the umbrella of personal awareness is like self regulation, and wellbeing, and I love teaching those self regulation skills. And under social responsibility are ideas, like how do you solve a problem in peaceful ways, and valuing diversity is one of the elements of social responsibility… In kindergarten, of course, all of those skills are going to be facilitated by an adult, and modelled. So I'm doing a lot of modelling, or role playing or talking out loud for the child. Like, oh, I'm feeling this way, what's in my toolkit for how I can help myself with this big feeling that I'm having? Or if it's like a conflict with students, they might not have the words or the skills yet for dealing with conflict resolution, and that's not expected yet… So I'm right in there, teaching peaceful methods of conflict resolution, that kind of thing. Or just even how to share space together, and how to be with other people who are having different feelings than you're having…And the idea is as they go through school, they'll gain an independence in those skills. (personal communication, September 5, 2020).

Whether the shift in the B.C. curriculum flagged by McFarlane will result, in the end, in improved outcomes for students in terms of mental health and addiction is yet to be seen (and is difficult to prove definitively). Regardless, the importance of education and training, starting in primary school, in conflict resolution, communication, self-awareness, etc. is worth considering in relation to the toxic drug poisoning crisis, as an absence of these skills is seen to increase individuals' social vulnerability. By supporting people in building these skills at a young age, tools are provided by which to navigate a complex and disjointed system; and, perhaps, to find, or create, meaning and purpose amidst a hyper-capitalist landscape.

3.5.4. Summary

These three 'upstream' services – housing, mental health and education, are all seen to play a key role in tackling the drug poisoning crisis. Each one, when appropriately strategized, resourced and operationalized, holds the potential to offer tools and wisdom necessary, along with the many layers of interventions outlined in Chapter 2, to overcome this crisis. Work is needed to identify elements within each service area that can be further evolved, and to enable appropriate levels of connectedness between these services and others.

While each of these service areas has played a significant role in shaping the drug poisoning crisis, it is important to acknowledge that many additional areas, including service areas related to foster care, child & family care, youth care, and systems related to income and wealth distribution, contribute to this complex and evolving crisis. Work is needed to explore these service areas and their relationship with the toxic drug poisoning crisis in greater depth.

Comox Valley Art Gallery Plaza
Photo by: Nadine Bariteau

Photo by: Kyle Little

Daryll

Photo by: Patrick Dionne

Photo by: Nadine Bariteau

4 RECOMMENDATIONS

Having travelled along a series of pathways examining the toxic drug crisis as it has unfolded in this country, province and region, and having explored the contributions and insights of people in the Comox Valley impacted first-hand, we now take a step back to ask:

- How might the Comox Valley community better-support people at the heart of this crisis?
- How might we reduce deaths, harm and stigma?
- How might we improve social cohesion and create progressive forms of systems change leading to better health and wellness outcomes for people who use, and have used, drugs?

In asking these questions, we also ask: who is responsible for making this change? Clearly the toxic drug poisoning crisis is complex and multi-faceted, necessitating a multi-faceted response. Given this fact, any meaningful solution will almost certainly require multiple leaders, organizations, community groups and individuals to work together towards this common goal.

The most obvious of these includes: federal, provincial and local governments, health authorities, health workers, criminal justice authorities, community downstream and upstream service providers, local businesses (especially in the downtown core), educators and educational leaders and, perhaps less formalized, groups of peers, family members and their allies. We believe that many more actors exist, however, who may self-identify as having change-making agency when reading this report.

In what follows, we outline a series of recommendations stemming from our research. While responsibility for change is suggested, we acknowledge the limits of our knowledge as related to the jurisdiction and potential of local, provincial and national systems and agencies. We ask those with power within these systems to engage as creative partners– imagining ways in which their agency can be applied towards the development of solutions.

Our hope is that readers consider these

recommendations as a concept sketch by which various actions are, in broad terms, defined. It is our collective work to 'fill in the gaps'... to imagine and create meaningful and sustainable solutions so as to end this crisis – by creating pathways leading to a significant shift.

1 Advocate the Federal Government for decriminalization of simple possession

Change Agent: Local Government

Acknowledging:

- The damage enacted nationally (and beyond) through criminalization of drug use, including the ties between criminalization and colonization, racism, and inequitable population control through over-incarceration of BIPOC (Black, Indigenous, People of Colour) populations;

- The growing movement (in B.C., and across Canada) spurred by health and community leaders, including provincial health officers, RCMP, and various levels of government, to recognize decriminalization as a viable 'way forward' in addressing the toxic drug crisis;

- The precedent set by the City of Vancouver, which, in 2020, passed a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize simple possession of drugs (while at the same time acknowledging the need expressed by many within Vancouver's PWLLE community for greater consultation as related to this advocacy);

We recommend local governments, working with local harm reduction leaders and Island Health, and in meaningful partnership with PWLLE, lobby the federal government for the legal power to decriminalize simple possession of illicit drugs. This recommendation involves asking the federal government for an exemption from the Controlled Substances Act to allow the possession of small amounts of illegal substances within municipal boundaries.

2 Re-commit to the operationalization of safe supply.

Change Agent: Provincial Government, Island Health, Harm Reduction Service Providers, College of Physicians and Surgeons British Columbia.

Acknowledging on one hand:

- The extreme toxicity at-play within the street drug market given the onslaught of fentanyl and its derivatives, as well as the toxicity now occurring through the mixing of street substances;
- The role safe supply can play in saving lives through the provision of clean drugs, while also stabilizing the life situations of people who use drugs;

And on the other:

- The limits surrounding safe supply, including its current lack of accessibility to casual and stimulant users;
- The hesitancy of some physicians to prescribe safe supply given the dangers of unmonitored opioid prescription;
- The propensity for safe supply to do harm if accompanied by a lack of monitoring and oversight;

We recommend Provincial Government, Island Health and Harm Reduction Service Providers urgently pursue the roll-out of safe supply. This includes making safe supply available (as medically/scientifically approved) to people in a streamlined, non-barriered fashion, enabling safe supply for people who use a range of substances (including opioids, but also stimulants); and developing and enacting systems of

monitoring (for instance, through static and mobile OPS sites) as well as physician monitoring (through oversight protocols enacted by the College of Physicians and Surgeons of British Columbia). In small communities located at a distance from large urban centres, work is needed to enact safe supply monitoring protocols in such a way as to eliminate travel barriers for people who use drugs – for example, through the provision of a 24/7 mobile OPS service.

3 Invest in full-spectrum drug testing.

Change Agent: Island Health, Harm Reduction Service Providers, Local Government

Acknowledging:

- The increased toxicity of the street drug supply

We recommend funds be allocated towards a full-spectrum drug testing system within the Comox Valley.

4 Reduce/eliminate stigma and racism within the health and criminal justice systems.

Change Agent: Provincial Government, Island Health, RCMP, Community Leaders.

Acknowledging:

- The stigmatization and racism experienced by participants in their interactions with the health and criminal justice systems – especially in relation to the hospital;
- The under-incorporation, within our current biomedical health system, of holistic frameworks of healing involving mind, body, spirit and emotion as well as collective notions of health found in the terms 'community' and 'belonging';
- The need expressed by participants for holistic, culturally-sensitive approaches to health and wellness;

We recommend Provincial Government, Island Health, RCMP, Community Leaders – take concrete steps towards the reduction/elimination of stigma and racism within the health and criminal justice systems, as well as a pursuit of holistic approaches to health. Such initiatives may include:

- **Inviting PWLLE into leadership roles within the health and criminal justice systems... creating leadership roles for PWLLE in Emergency departments of hospitals; and in policing;**
- **Embracing ongoing cultural safety and anti-sigma training for staff of health and criminal justice institutions;**

- **Developing hospital discharge protocols that enable patients without transportation, especially those released in the middle of the night, to stay safe;**
- **Implementing patient advocacy positions and programs in hospital that foster anti-racism and anti-stigmatization principles;**
- **Receiving and analyzing the feedback of PWLLE in relation to the health care they have received, and hospital care in particular – with an aim to reduce stigma and racism, and to provide high-quality care from a humanistic framework;**
- **Developing hiring practices that actively encourage/preference people committed to an anti-stigma, and anti-racism, stance;**
- **Seeking ongoing guidance and leadership from Elders/Traditional Knowledge Keepers and Cultural Leaders; regarding ways in which to bring Indigenous health and wellness paradigms into hospitals, health care and criminal justice systems;**
- **Investing in strong relationships between health sites (especially hospitals) and community health service providers, both harm reduction and recovery-based, and in commitments to coordinate patient care across these platforms;**
- **Exploring a role for police for in responding to toxic drug poisoning events;**
- **Equipping police with ongoing anti-stigma and anti-racism training;**
- **Developing and funding restorative justice paradigms.**

5 Reduce/Eliminate stigma and racism within the community at-large

Change Agent: Community Leaders

Acknowledging:

- The race and stigma-based injustices suffered by numerous participants at the hands of the general public;
- The principles of equity, diversity and inclusion as core within the pursuit of healthy communities;
- The need to enable understanding and relationship between people who use drugs and the wider community – and to provide opportunities for this group to have value and purpose within - to 'matter to' - the wider community;

We recommend the enactment of anti-stigma and anti-racism learning and development initiatives on all levels of our community – to be championed by community agencies, businesses, schools, governments, health authorities, police, criminal justice systems, 'opinion leaders', etc. S may include:

- **The development of anti-stigma and anti-racism workshops, events, courses, community gatherings, etc;**
- **The inclusion of anti-stigma and anti-racism training in professional development and staff skills enhancement contexts;**

6 Increase the accessibility and connectivity of OPS Services

Change Agent: Island Health, Harm Reduction Service Providers, Local Government

Acknowledging:

- The need expressed by participants for geographically-accessible OPS services that operate 24/7 and facilitate additional forms of drug consumption than those currently available;
- The importance of linking OPS services to a wide range of 'wrap-around services';
- The resistance many participants express to clinical environments;

We recommend Island Health and Harm Reduction Service Providers such as AVI Health and Community Services activate a meaningful and fulsome dialogue with the using community with an aim to develop a comprehensive OPS and Harm Reduction Services paradigm. Solutions may include:

- **Creating a 24/7 mobile service;**
- **Activating several OPS sites throughout the Valley;**
- **Integrating OPS services with a wide range of wrap-around services;**
- **Housing OPS services within community-focused, rather than clinical, environments;**
- **Enabling OPS witnessed consumption of additional methods of drug consumption, including inhalation.**

7 Increase the accessibility and connectivity of Recovery Services

Change Agent: Island Health, Recovery Service Providers, Local Government

Acknowledging:

- The difficulties (expressed in wait times) of participants in gaining access to medical detox platforms, and the frequent need for participants to access these services from out of town;
- The lack of 'streamlined' connectivity apparent between the different facets of the recovery system;
- The lack of long-term sober living rehabilitation support systems, and the importance of such systems, expressed by participants, in enabling people in recovery to maintain sobriety;
- The need for a range of aftercare supports for people in recovery;

We recommend Island Health and Recovery Service Providers activate a meaningful and fulsome dialogue with the PWLLE community, with an aim to develop a comprehensive, immediately accessible and streamlined system. Solutions may include:

- **Development of a medical detox centre in the Comox Valley -one that holds capacity for rapid access;**
- **Development of long-term sober living housing solutions;**
- **Development of aftercare programs that 'meet people where they are', including programs that include cultural safety and support.**

8 Develop a 'Hub'

Change Agent: Island Health, Harm Reduction and Recovery Service Providers, Local Government

Acknowledging:

- The fragmentation and 'siloing' of Comox Valley addiction services as identified by participants;

We recommend the development of a coordination hub – a place that carries in-depth knowledge of, and relationship with, the organizations/entities delivering medical, harm reduction, mental health and recovery- based care in the Comox Valley. This hub works to better-coordinate and dovetail services – leading to more coherent systems of care.

9 Create a PWLLE Leadership Group

Change Agent: Local Government

Acknowledging:

- The difficulties expressed by participants in accessing such fundamental services as water, power, public washrooms and a place to camp;
- The experiences participants shared of being perpetually 'moved along' and/or hassled by bylaw and/or law enforcement officers, leading to a perpetual state of displacement and the inability to stabilize their living situations;
- The links made by participants between the achievement of stabilized living scenarios and the reduction in harm;

We recommend the development of leadership teams of PWLLE, connected with municipal staff, whose wages are compensated by Local Government, and whose key task is to recommend changes to civic services, infrastructure and bylaw so as to enable the human rights for PWLLE in the enactment of changes to civic services and infrastructure.

10 Pursue ongoing improvements in housing, mental health, education

Change Agent: Local Government, Mental Health Service Providers, Island Health, Education Institutions.

Acknowledging:

- The role played by 'upstream' services in creating the conditions for, and/or helping to solve the toxic drug crisis;
- The 'housing first' sentiment expressed by numerous participants, which shows housing as a necessary first step towards stabilizing living situations, allowing PWLLE to then pursue harm reduction and recovery;
- The need expressed by participants, especially parents, for more comprehensive mental health services, including for mental health providers who hold long-term relationships with people who use drugs, and who are able to provide ongoing, knowledgeable guidance;
- The importance placed on education, especially education of young children, in the plight to equip people with the skills they require to communicate, develop resilience, and to belong within a larger social context;

We recommend that continued emphasis and engagement occur between Local Government, Mental Health Service Providers, Island Health and Education Institutions, with an aim to improve and coordinate services, and create the foundations for a reduction in harm.

11 Conduct Gaps and Opportunities Analysis

Change Agent: Island Health, Service Providers

Acknowledging:

- The needed for more research related to the service ecology at-play in the Valley, including an analysis of its strengths, weaknesses and opportunities;

We recommend the activation of a research project designed to map this ecology. Such a map may include:

- **In-depth documentation of the service provided by harm reduction and recovery agencies, soliciting data surrounding their availability, immediacy, statistical uptake, principles, etc., through in-depth interviews with program, service and organizational leaders;**
- **Identification of key gaps, successes, growth potentials, and comparison/contrast with other community service ecologies.**

12 Invest in PWLLE as Change Leaders

Change Agent: Island Health, Service Providers, Local Government, Community at large

Acknowledging:

- The importance of PWLLE in developing solutions to the crisis;
- The need for equitable, human-centred policy development created by those most impacted;

We recommend the inclusion of PWLLE in leadership roles throughout the spectrum of care addressed in this report. The success of policy changes designed to address the toxic drug poisoning crisis depends, we believe, on the development of a radically unique, grassroots approach to policy development, one that places PWLLE and their allies in leadership roles.

4.1 Summary

These recommendations sketch various pathways forward, and together create a 'potentials framework' intended to be used by community and institutional leaders to make progress in reducing harm, deaths and stigma attached to the toxic drug crisis.

5 Conclusion

In this report, we've explored key factors feeding this toxic drug poisoning crisis in the Comox Valley (and beyond) – as identified by people at the heart of this crisis – people with lived and living experience, their family members and front-line workers. We've examined the history of drug legislation in this country, including ways in which this history is tied in with colonization, race-based power dynamics and stigmatization. We've seen how these dynamics are carried forward into the present day. We've also seen how both the 'decriminalization' and 'safe supply' agendas reposition drug use as a public health issue, rather than a moral or criminal issue – and in so doing remove elements of stigma and shame. While we acknowledge and advocate this perspective, we simultaneously acknowledge the merits of an argument that shows the toxic drug crisis as existing beyond individual health and wellbeing; as indicative, also, of a society whose core philosophies, centred around individualism and consumerism, undernourish our need as humans to connect, to cultivate meaning and purpose, and to belong within a context that is larger than ourselves.

If, as many claim, the 'opposite of addiction is connection', then a response to the toxic drug crisis necessarily involves a drive to connect people in meaningful ways with one another, and with their communities. The recommendations outlined in this report identify a series of practical avenues to foster such connectivity – both through policy change that underscores the fundamental humanity and worth of PWLLE, and through community change in which we, as individuals, families, groups, publics, leaders, etc. collectively rise to a more inclusive understanding of what it means to live and exist together.

In closing, I wish to once again recognize and thank all who gave their voices, insights and stories over the course of this project, and the Walk With Me team members, with whom I've had the honour to walk alongside. In holding these stories close, and in walking with them alongside our community, we hold out hope for a future where dehumanization, stigma and racism are eradicated; where harm is diminished, community systems are nourished, and where people no longer die from preventable toxic drug poisoning deaths.

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