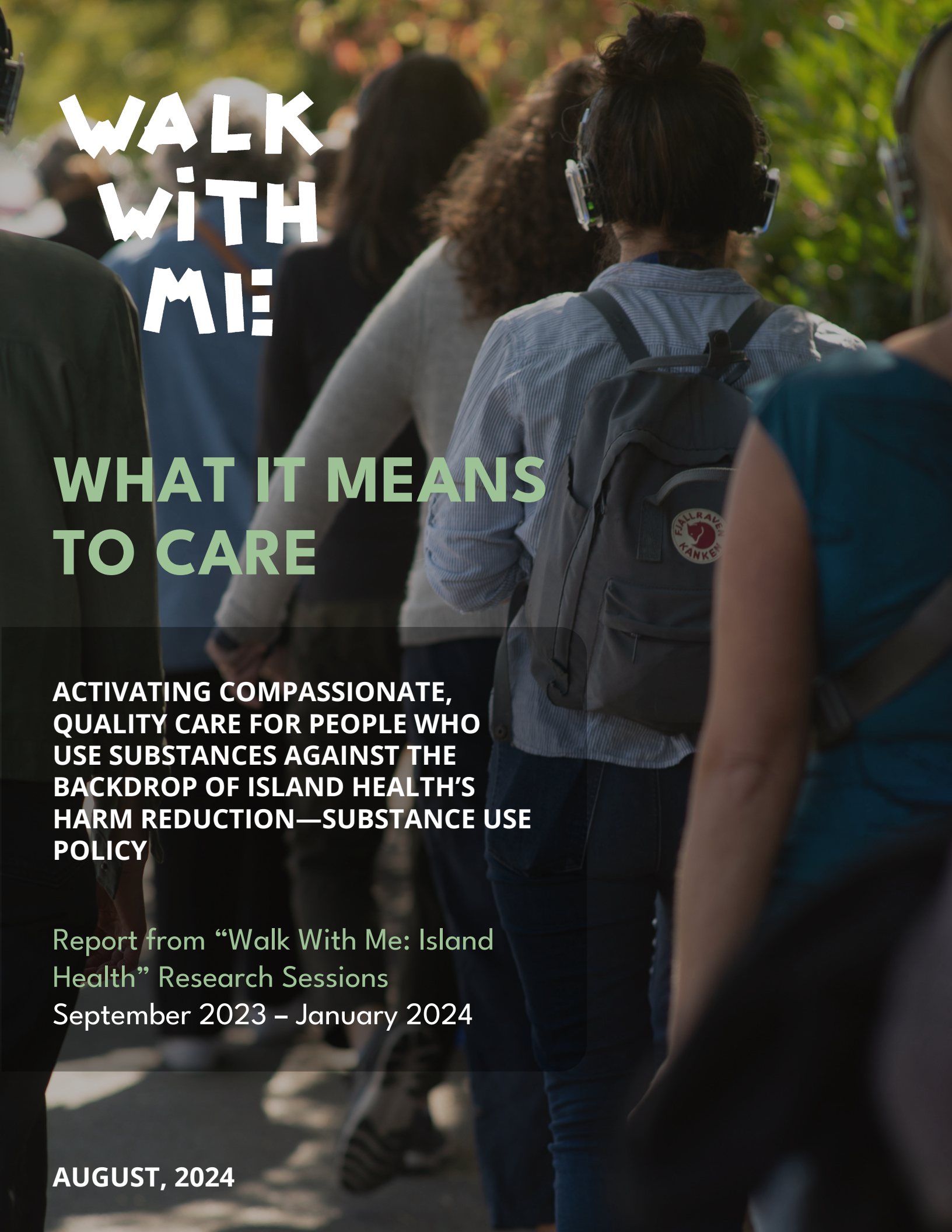

WALK WITH ME

WHAT IT MEANS TO CARE

ACTIVATING COMPASSIONATE, QUALITY CARE FOR PEOPLE WHO USE SUBSTANCES AGAINST THE BACKDROP OF ISLAND HEALTH'S HARM REDUCTION—SUBSTANCE USE POLICY

Report from "Walk With Me: Island Health" Research Sessions
September 2023 – January 2024

AUGUST, 2024

With Gratitude to Our Partners

And Funders

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LAND AKNOWLEDGEMENT

Walk With Me is honoured to work on the unceded territories of the Coast Salish, Nuu-chah-nulth and Kwakwaka'wakw people. We give respect to this land and to the people who have been its caretakers since time immemorial.

DEDICATION

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

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

ETHICS STATEMENT

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

ABSTRACT

Since labelled a provincial emergency in 2016, the toxic drug poisoning crisis in B.C. has claimed over 14,000 lives. Government, health and community service providers alike have struggled to find solutions to the crisis and have developed numerous interventions aimed to reduce deaths, harm and stigma. Despite these efforts, toxic drug deaths continue to climb, with 2023 recording the most fatalities ever and no sign of slowing in 2024.

"Walk With Me" is a research and community action project developed in small B.C. communities, beginning in Comox Valley and Campbell River, B.C. The project began in 2019 as a partnership between Comox Valley Art Gallery, Thompson Rivers University and AVI Health & Community Services, aiming to develop humanistic and systems-based solutions to the toxic drug poisoning crisis.

Beginning in 2021, the Walk With Me team was invited to work with Island Health to engage staff in facilities across Vancouver Island in a multi-tiered research initiative. The research invited staff from these facilities join "Story Walks"—a series of guided listening journeys foregrounding local first-hand testimony of the crisis. Following the walks, staff were invited to sit in-circle, and to share insights and respond to the questions: "What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?" and "How can Island Health better support people at the heart of the toxic drug poisoning crisis?" In collecting and analyzing staff insights, the project aims to illuminate ways forward for Island Health towards progressive institutional change.

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1 INTRODUCTION

Walk With Me is a research and community action project developed in response to a toxic drug poisoning crisis that is blindsiding municipal governments, institutions, and communities large and small across the country. The crisis is having a heavy impact in B.C. Since it was labeled a provincial emergency in 2016, illicit drug toxicity deaths have totalled over 14,000.[1] For governments, communities, front-line workers, families, and people with lived and living experience (PWLLE), the crisis can feel insurmountable. *Walk With Me*, a research and community action project coordinated through the Comox Valley Art Gallery in partnership with Island Health, Vancouver Island University, Thompson Rivers University, AVI Health and Community Services, and an array of community partners, brings together diverse stakeholders through a process of cultural mapping to envision an end to the toxic drug poisoning crisis.

As its central research question, *Walk With Me* asks: **"How can community-based research investigating the toxic drug poisoning crisis help save lives, reduce harm, improve social cohesion and create systems change for populations facing the crisis first-hand in small and rural communities?"** This project aims to understand how this crisis is playing out uniquely in B.C.'s small cities and to shine light on the stories of human loss, crisis and resilience emerging through it.

Beginning in 2023 and building on previous work with Island Health that occurred in 2021-2022, *Walk With Me* received ethics approval to work within Island Health facilities. As part of this work, Island Health staff teams were invited to listen to (and walk with) audio tracks compiled by the *Walk With Me* team that foregrounded the voices and stories of PWLLE. Within these 18 sessions, which occurred between September 2023 and January 2024, staff were invited to respond to the following research questions: **"What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?"** and **"How can Island Health better support people at the heart of the toxic drug poisoning crisis?"**

This report emerges from these 18 sessions. It documents and analyzes staff responses to these questions and presents a series of ensuing change recommendations. The report includes the following sections: Introduction (Chapter 1), Context (Chapter 2), Project History and Methods (Chapter 3), Findings (Chapter 4), Recommendations (Chapter 5), and Conclusion (Chapter 6), and includes an Appendix that details the contextual factors influencing the rise of the toxic drug poisoning crisis in Canada and British Columbia (Appendix A). Together, these chapters shine light on how harm reduction and substance use policies are being taken up across sites and levels of the organization, and point to potential pathways forward for Island Health in reducing deaths, stigma, and harm through systems change based innovation.

2 CONTEXT

The following section provides a broad overview of the contextual factors influencing the rise of the toxic drug poisoning crisis in Canada and British Columbia. These factors are outlined in further detail in Appendix A of this report.

2.1 Background

In April 2016 BC's Provincial Health Officer declared a public health emergency due, in-part, to the high toxicity of fentanyl in the illicit drug supply. The province responded to the crisis through a range of interventions including: public education, targeted information campaigns, increased access to trauma and mental health counseling, increased access to opioid agonist therapies, distribution of naloxone kits, passage of legislative changes, increase of toxicological testing of drugs, expansion of harm reduction services (i.e.: establishing toxic drug death prevention services, expanding supervised consumption sites, and implementation of a limited "safe supply" program), development of a ministry focused on mental health and addictions, etc. Yet in spite of these interventions, the rate of toxic drug-related deaths has continued to rise.[1,2]

The crisis has been fuelled by a "perfect storm" that includes an increase in the toxicity of drugs, over-prescription of opioid-based pain medication, criminalization of drugs, the COVID-19 pandemic, and the rise in social dissonance factors such as unemployment, housing unaffordability, and income disparity. These factors, coupled with ongoing stigma, racism, erosion of mental health supports and erosion of education, have created and exacerbated the crisis. In addition, a multitude of harms are experienced by individuals, families, workers, institutions, and social systems in association with toxic drug poisoning deaths. The rising figures suggest immense risk for current illicit drug users and describe an increasingly heavy burden carried by health agencies providing support to those at the heart of the crisis.[2,3]

2.1.1 Where is the crisis unfolding and who is most impacted?

Mounting evidence has demonstrated that the toxic drug poisoning crisis is not confined to large urban centres. Indeed, as data from the BC Coroner's Service has shown, unregulated drug toxicity deaths in small cities and towns are increasing, and in some cases surpassing per-capita growth rates in large urban centres.[1] Between 2016 and January 2024 (the most recent data available at the time of writing), Island Health recorded 2,368 unregulated drug toxicity deaths. Within the Island Health region, in 2023 we saw the highest per-capita (per 100,000 people) rates of unregulated drug toxicity deaths in Central Vancouver Island (67.1), then North Vancouver Island (62.4), and finally South Vancouver Island (38.5).[1] Here we see the North and Central Island regions, home to small cities and rural and remote landscapes, as more strongly impacted on

a per-capita basis than the more densely populated South Island Region.

The demographics most impacted include: men ages 30-59, who accounted for 76% of unregulated drug toxicity deaths in BC as of January 2024, and First Nations communities.[1] In 2023, First Nations people died at 6 times the rate of other BC residents, vs. 5.3 times in 2022.[4] Additionally, people who are under and unemployed, people in the trades and transportation industries, and people who are grappling with pain and mental health issues are overrepresented in toxic drug-related fatality rates.[5]

2.1.2 What can be done?

We know that there are many actions that can be taken to reduce harm from toxic drug poisoning. In BC, pragmatic downstream solutions have been rolled out to varying degrees, such as: increasing access to safe supply and opioid agonist therapy (OAT), decriminalization of illicit substances, increasing access to mental health supports, and better management of opioid prescriptions. Upstream solutions exist as well, which consider social determinants of health such as housing, education, and poverty reduction. Taken together, these factors represent a systems approach to reducing harms caused by the toxic drug poisoning crisis.

It is within the near-term power of our governments and health institutions to make rapid progress with respect to Harm Reduction, including expanded access to "safe supply," opioid agonist therapy (OAT), and mental health services. In 2020 the Province announced it would begin to offer drug users safe supply from a wider range of health professionals than were previously approved to offer this service.[6] Yet the roll-out of safe supply has, especially in small cities, been slow, highlighting inequities in access.[7] Safe supply programs have also faced scrutiny and backlash from both politicians and the public, even as evidence from the BC Coroner's Service continues to show that safe supply programs have not contributed to toxic drug poisonings.[1,8] In addition, a recent report from BC's Provincial Health Officer has demonstrated some of the beneficial impacts that safe supply programs have had on the lives of people who use drugs.[9] Despite these cautiously optimistic results, the future of safe supply programs continues to be a subject of strong political and public debate.

OAT is a treatment strategy that has been in-place within B.C. for many years. Prescriptions such as methadone (Methadose) and buprenorphine (Suboxone)—long-acting opioid drugs—are given to lessen and replace dependency on shorter-acting opioids such as heroin, oxycodone and fentanyl. OAT reduces opioid-related morbidity and mortality, and this is increasingly so as synthetic opioids such as fentanyl become more dominant in the illicit drug supply.[10] Rural and remote communities in BC face serious access barriers and lower quality service delivery with respect to not only OAT, but also mental health services, for which there are severe shortages.[11,12] Recent Provincial budgets and programs suggest that the BC government is working to address service imbalances across the province.[13] The changes cannot come soon enough.

It is within the near-term power of regulatory bodies to find safer systems for managing prescription opioids and tracking how patients are managing their pain. Medical institutions feed opioid dependency through prescription. Canada ranks "second only to the US in per capita consumption of prescription opioids" as a nation.[14(p1)] Progress is being made to control excessive opioid prescription, however, regular opioid users may seek illicit supply from the street if they are denied pharmaceutical supply and are not supported in transitioning from

their dependency.[15] More can be done to address this issue.

It is also possible to decriminalize illicit drug use, as shown by recent actions undertaken by the BC government. Criminalization compounds the harms of unregulated drugs. Rooted in overt racist politics, Canada's drug criminalization experiment officially began with the *Opium Act* of 1908.[16,17] Though the LeDain Commission recommended a suite of decriminalization policies in 1973, criminalization efforts only increased until 2016 with the release of the *Canadian Drugs and Substances Strategy*.[18,19] Today, limited decriminalization of small amounts of unregulated substances is in effect for all of BC from January 31st, 2023 to January 31st, 2026, a positive first step to address the toxic drug poisoning crisis.[20] While there has been negative political and public response to decriminalization in BC, particularly at the municipal level, the evidence demonstrates that where governments have actively pursued decriminalization, they have generated enormous savings while reducing drug toxicity deaths and accompanying social trauma, as well as crime.[21–23]

In addition to the near-term evidence-based calls to action, dominant proposed solutions also advocate for changes impacting the social determinants of health, whose outlooks are driving people towards social isolation and precarity. The housing crisis, in particular, is driving precarity. In the Comox Valley alone, the benchmark price of a single-family home has increased from $505,300 in February 2019 to $829,500 in February 2024—an increase of 164%.[24] In Campbell River, the benchmark price of a single-family home was $417,900 in February 2019, and was $661,600 in February 2024, a 158% increase.[24] Housing unaffordability (both within the rental and ownership markets) directly contributes to homelessness, poverty, and addiction in North Vancouver Island.

Finally, addiction is a response to the absence of connection, belonging and collective aspiration. In this view, many forms of physical and emotional distress are a normal response to our failure as a society to acknowledge the consequences of growing inequity. For a portion of the population, the response to increasing erosion of social fabrics occurs in the form of addiction (including drugs and alcohol, but also shopping, gambling, working, exercising, power, money, more). When unchecked, these habits temporarily fill the void left by a society consumed with free-market logics at the expense of human connection (see Appendix A, D3).

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

2.2 Island Health: leadership in harm reduction

Island Health holds a leadership role in implementing harm reduction and substance use policies and in confronting the toxic drug poisoning crisis—a reality recognized by staff participants in this project and applauded by our project team. In recent years, Island Health has spearheaded several key harm reduction programs and initiatives designed to address the crisis. These include (but are not limited to):

- Learning about Opioid Use Disorder, "LOUD in the ED." This program, which hired Peer staff within emergency departments to support patients with mental health and addiction needs, has made big waves in the Campbell River emergency department. The program recognizes that for 21%

of people with Opioid Use Disorder experience, their first point of contact with the medical system is through an emergency department (ED). The program has developed systems changes within the ED designed to make a difference in the lives of those impacted by the toxic drug poisoning crisis.[25,26]

- The recent implementation of the Care and Connections Kiosk program has allowed for the hiring of more Peers in the ER. This program, introduced in 2023 as a pilot in three acute care sites, provides harm reduction resources and Peer support to people who use substances in hospitals.[27]

- Preparing, budgeting, and issuing requests for proposals to provide harm reduction services like safe supply, safe injection and inhalation sites, and opioid agonist therapies.[28]

- Launching a campaign to support those who use substances, targeting men aged 30-59 who represent the majority of toxic drug deaths.[29–31]

- Exploring and activating novel partnerships like mobile service vans for youth wellness.[32]

- Developing and releasing an Island Health-wide "Harm Reduction—Substance Use" policy that directs required organizational practice and behaviour. This policy outlines significant aspirations and strong evidence-based expectations for baseline care, values and quality of service delivery. Island Health staff and leadership can begin to "test" their decisions and actions against the expectations in this policy to see if they are retrogressive, aligned, or exceptional.[33]

- Conducting ongoing internal evaluation efforts to understand if and how harm reduction education and the Harm Reduction — Substance Use policy is working.[34,35]

- Harnessing the energy of the Island Health Innovation Lab to promote internal collaboration and external partnerships that can break down barriers and create actionable, patient-centred solutions to the toxic drug poisoning crisis.[36]

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

Of particular relevance to this report is Island Health's recently implemented Harm Reduction—Substance Use Policy, which forms a backdrop to the systems change occurring across sites and within the organization. This policy guides Island Health staff to pursue environments and practices that are non-judgemental, *strengths-based and person-centred*, non-stigmatizing, *respectful, culturally safe*, compassionate; flexible and adaptable; trauma and violence informed; and guided by the social determinants of health.[37(p2)]

These principles represent a baseline harm reduction philosophy for Island Health sites and departments to take up.

Our findings show that work is still needed to bring Island Health practices into alignment with the philosophy expressed in the Harm Reduction—Substance Use Policy. Participants spoke of the need for concerted, system-wide efforts to embed these principles into the organization's culture and practices. In what follows, we will take readers through key insights that highlight areas in which the Policy's promise has not yet been realized; areas where

individual, structural and organizational stigma are seen to frustrate the vision of providing compassionate, quality care for people who use substances.

At the same time, our findings also speak to a spectrum of unique and powerful ways in which the philosophies embedded within the Harm Reduction—Substance Use Policy are being taken up within the organization. Systems change is happening, but work is needed to accelerate the process.

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

2.3 Summary

A multitude of systemic factors drive individuals towards dangerous substances. This section has acknowledged the numerous factors implicated in the dramatic increase in toxic drug-related deaths brought about since 2016 when the crisis was labeled a provincial emergency, and has discussed how the crisis has unfolded statistically on Vancouver Island. It has also reviewed the development of a slate of countermeasures within Canada broadly, in B.C., and in Island Health, that have emerged in recent years to combat toxic drug-related deaths. The insights provided by Island Health staff in this report are set against this backdrop and call for continued progress by Island Health to dramatically reduce the harms and deaths associated with this crisis.

3 PROJECT HISTORY AND METHODS

While this report documents the insights emerging through *Walk With Me*'s recent work with Island Health, it draws on methods and insights that have been developed by the project and with our collaborators over the past five years. *Walk With Me* began in 2019 in the Comox Valley of BC. From the outset, our work has involved sitting "in circle" with people with lived and living experience of the crisis, Peers, their family members, and, as in the case of our work within Island Health, health care staff and frontline workers. Using a research methodology known as "cultural mapping," our circles were hosted by a research team including Elders/Knowledge Keepers, artists, Peers, community-engaged researchers, and outreach workers. Within our circles, participants were invited to draw and/or talk about the ways in which the crisis has impacted their lives and communities, and were provided an honorarium, food, art supplies, and various layers of support including cultural safety and outreach. During the circles, powerful insights into the crisis surfaced, and were recorded, guided by comprehensive ethics protocols.

In the fall of 2020, *Walk With Me* began sharing these collected insights in the form of "Story Walks"—guided audio journeys that take participants on a 40 minute walk while they listen to audio recordings of the voices and insights gifted to the project by PWLLE, Peers, their family members, and front line workers. Participants travel through local neighbourhoods, under bridges, through parks, etc.—while allowing the stories, transmitted via mobile headsets, to "wash over them." Participants then sit together in-circle, guided by Elders and researchers, and are invited to reflect on and respond to the stories shared. In the Spring of 2021, the *Walk With Me* team was invited to bring the project into Campbell River. Again, we collected and recorded primary stories, insights, and recommendations from PWLLE of the crisis and Peers, spoke with family members and front-line workers. In the Fall of 2021, we began walking with the stories and sitting in-circle with the wider community, and the results of this work in Campbell River have recently been consolidated and published in a community report entitled *Maya'xala: Cultivating Community Respect in the Midst of the Toxic Drug, Trauma, and Housing Crises.*[2]

In 2021, Walk With Me was invited to take our project into Island Health. We began sharing story walks and circles with groups of front-line staff in Island Health acute care facilities. In the Summer of 2021, we received ethics approval to conduct our work within Island Health not only as knowledge dissemination—conducting primary story walks—but as research, where we systematically collected the secondary reflections and feedback of staff who understood that their voices would be carried to leadership. We called this branch of the project "*Walk With Me*: Island Health." From June 2021 to June 2022, we conducted research with over 200 staff from various Island Health facilities, hosting story walks

on the lawns of hospitals and inviting staff to participate in sharing/research circles. Our work was anchored by the research question **"What can Island Health do to better serve those at the heart of the toxic drug poisoning crisis?"** The results of this work were published in our 2022 report entitled *Pathways Forward - Island Health & the Toxic Drug Poisoning Crisis*.[3]

The success of this initial foray into research within the organization led to a continuing collaboration between *Walk With Me* and Island Health. Beginning in September 2023, we once again began to conduct story walks and undertake evaluative research with staff at various facilities across the Island Health service region. Through January 2023, we conducted 18 research sessions and received insights from over 240 staff from 10 facilities. We hosted 9 sessions with 94 Acute Care staff, 2 sessions with 34 Community Health Services staff, 2 sessions with 36 Mental Health and Substance Use staff, 1 session with 10 Administrative staff, 2 sessions with 28 Long Term Care staff, and 2 sessions with 39 Urgent Primary Care Centre Staff across the North, Central, and South Vancouver Island Heath Service Delivery Areas. The work was guided by the following two research questions: **"What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?"** and **"How can Island Health better support people at the heart of the toxic drug poisoning crisis?"** This report constitutes the second volume in a series of publications designed to bolster Island Health's capacity as a learning institution to address the toxic drug poisoning crisis. We see this report as one step in a pathway towards institutional systems-based transformation.

3.1 Why use cultural mapping as a core methodology?

Cultural mapping, a community-engaged research methodology, can provide a bridge of connectivity between PWLLE, Peers, family members, and frontline social service providers, while also mapping connections between these groups and government, policymakers, and the broader public. Over the last 30 years, cultural mapping has gained international currency as an instrument of collective knowledge building, communal expression, empowerment, and community identity formation.[38,39] Practitioners of cultural mapping combine verbal story and insight sharing with artistic sharing to foster deeper understanding about lived realities.

Our primary mode of mapping occurs through a draw-talk protocol, wherein PWLLE either draw about their lived experience, and/or speak to their experiences in the form of circle-based semi-structured interviews. In *Walk With Me*: *Island Health*, by contrast, Island Health staff listened to stories derived from our primary mapping while going on a story walk, and then engaged with the Walk With Me team in a process of reflection, responding to the questions: **"What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?"** and **"How can Island Health better support people at the heart of the toxic drug poisoning crisis?"** Island Health staff participated in the following sequence of activities with Walk With Me in preparation to discuss the crisis and better support one another:

- The *Walk With Me* team collaborated with local site managers to invite staff to participate in the sessions, using invitations pre-approved by Island Health ethics.

- Participants gathered together with the *Walk With Me* research team,

consisting of an Elder/Knowledge Keeper, researchers, Peers and outreach workers, in groups as large as 26 individuals. Participants signed in and reviewed research ethics protocols and consent forms. With the help of Indigenous leadership, *Walk With Me* oriented the group to the project, and to the traditional practice of sitting in circle to listen and share. Participants were reminded of the consent process verbally, informed of what they were about to hear, and instructed to not "carry the stories" as their own. Participants were asked to honour the stories by holding them in confidence and were given options for removing themselves from the walk and accessing supports if listening became overwhelming.

- Wireless headsets were then distributed to participants. A 40-minute collection of audio stories, gathered from people with lived and living experience of the crisis, was then broadcast to participant headsets so the group could listen to the same stories simultaneously. The *Walk With Me* team then took the participants on a specific route from the hospitals that resonated with the stories.

- After the walk, Island Health participants gathered back together and were offered food. The group sat in circle with the research team, and the protocols for deep and respectful listening were reviewed by our Elder. The group was reminded that their responses were being recorded for research purposes. Moving to the left in circle following Coast Salish tradition, participants were invited by the facilitator to share their reactions to the stories and respond to the research questions.

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

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

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

Our objective in reviewing these methodologies is to highlight the unique environment in which Island Health staff were prepared to listen to the stories and respond to the research questions. This method was designed to inspire Island Health staff to express their ideas for making systems change while simultaneously fostering community and understanding. Data-collection sessions were 1.5 hours in duration, located at Island Health facilities. We met often in tents, and with fire-pits, outside the facilities—an act that enabled staff to foreground novel and humanistic, as opposed to pre-determined (through physical association

with pre-existing clinical contexts), forms of insight. The insights, recommendations, and thematically organized content in this report are built upon the voices of Island Health staff emerging through this context, and the voices of PWLLE who inspired them to speak.

3.2 What are the project's objectives?

Key objectives include:

- Enabling new ways of thinking about the toxic drug poisoning crisis as it is plays out within *Walk With Me*'s communities of research and within small B.C. cities generally—leading to systemic forms of change;
- Exploring 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;
- Developing insights surrounding the crisis leading to the design of progressive change and transformation;
- Creating innovative, participatory, arts-based research models pertaining to the crisis that are produced through multi-level community agency; and
- Refining an arts-based methodology to facilitate open conversations about difficult problems in society in the service of uncovering common ground and humanity.

3.3 Limitations

This report provides a broad overview of key themes, ideas, and suggestions for change emerging from Island Health staff in response to the central research questions we have outlined. We foreground the stories and insights of Island Health staff participants who shared with us, documenting their insights in a way that allows them to be seen and heard in new ways.

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

A second limitation relates to the emotional density of the stories. The act of listening together to stories of lived experience was an emotionally rich and intense experience which often resulted in an immediate feeling of solidarity between participants. This emotional investment may have informed participant engagement and resulted in participants sharing particular insights at the expense of others. We present these limitations for consideration alongside our recommendations.

Moving forward, we see value in collecting survey data and performing statistical/ quantitative analysis that examines the inner frameworks at play within Island Health (looking at key markers of support for people at the heart of this crisis). Such analysis will allow a deeper understanding of participant insights to emerge (collecting data from participants related to age, gender, etc. to better situate and position staff knowledge). Such analysis will need

to be accomplished through additional conversation and partnership with Island Health.

3.4 Summary

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

4 FINDINGS

Our research findings, as presented in this report, foreground a gradual process of change in service delivery and uptake of harm reduction policy related to the toxic drug poisoning crisis within Island Health, with the caveat that there are still large gaps in provision that need to be addressed across service delivery sites and departments in the organization. Overall, our team has identified encouraging signs of transformation in Island Health since our last report, while recognizing that there are still many opportunities for real systems change[..3]

The findings we present here derive from research sessions with over 240 Island Health staff at facilities across Vancouver Island from September 2023 through January 2024. After engaging in a story walk (described in Section 3.2), staff were asked to respond to the central research questions: **"What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?"** and **"How can Island Health better support people at the heart of the toxic drug poisoning crisis?"** Researchers asked follow-up questions when appropriate and gave participants the chance to elaborate on the themes and concepts shared.

The insights provided by Island Health staff are organized into three sections and expanded upon across the following chapter. The first section, **Structural Barriers**, outlines some of the upstream challenges such as trauma, stigma, and housing that are influencing Island Health staff in relation to the toxic drug poisoning crisis. While such structural issues are often beyond the control of frontline staff, leadership, or even the organization, they *do* affect their work in that they shape the lives of the Peers with whom they interact. A second section describes **Working Conditions and their Impacts on Island Health Staff**. Staff candidly shared with us some broader issues that affected their work-lives, and in turn, shaped their interactions with Peers, often in negative ways. The third section, **Degrees of Uptake**, highlights some of the gaps and improvements in Island Health's existing system of harm reduction service delivery to address the toxic drug poisoning crisis. As we listened to the voices of Island Health staff, it became clear that areas of deficiency identified by some staff were being noted as areas of improvement by others, indicating that the adoption of harm reduction principles was happening by degrees and in different ways across service sites and departments.

4.1 Structural barriers

Island Health staff spoke to structural factors that were influencing their work and their interactions with Peers, as well as ways in which these factors affected the lives of Peers more broadly. Staff participants across Island Health sites spoke about the interconnected negative effects of **trauma, stigma,** and a **(lack of) housing** on the lives of Peers. Such issues in many

cases emerge from sites beyond the scope of Island Health, but nonetheless affect the lives of Peers and the work of staff in important ways. Trauma—for example, intergenerational trauma passed on through family histories of addiction and violence and/or experiences with colonization and residential schools, or long-term trauma experienced at the hands of the health care and/or education systems—is a real factor affecting Indigenous peoples' present-day interactions with the medical system.[40] Stigma, likewise, is a well-acknowledged reason why Peers (Indigenous or not) choose to hide their drug use and are often averse to seeking medical attention. Broader public opinions on drug use, as well as previous stigmatizing experiences in interactions with public systems, form part of the reason why Peers might avoid (or be wary of) formal health care settings.[41(p11)] In turn, intersecting issues of trauma and stigma, and accompanying lack of stability, may also shape Peers' ability to access housing, thereby exacerbating the existing housing and homelessness crisis.[42,43] In the following section, we build on these broader insights to highlight the voices of the Island Health staff who generously shared with us, and highlight the effects of structural issues such as trauma, stigma, and lack of housing, specifically as they pertain to care in Island Health sites.

4.1.1 Trauma

In reflecting on their experiences of the story walk, staff shared candidly about the ways in which trauma affects the lives of Peers and shapes interactions with the formal health care system amid the toxic drug poisoning crisis. As one participant stated, **"this [is] a crisis about trauma, and a lack of community and connection"** *[Deidentified Participant]*. Others agreed, also highlighting the societal disconnection that accompanies trauma:

> "I think something that really occurred to me [is that] drug use [is] the tip of the iceberg. And then underneath [that] iceberg, an ocean of trauma and loneliness, and lack of connection and lack of community."
>
> *[Deidentified Participant]*

> **"In most cases [people] are like [...] 'No, I don't talk with people who are suffering from addictions [or] people who have trauma because I stay in my community that protects me from having to integrate into those other communities.' And I think that's what we're missing.**
>
> *[Deidentified Participant]*

Staff also noted how some Peers are having to **"leav[e] their community [...] to make a new one"** to **"break free from the generational trauma that they had experienced"** *[Deidentified Participant]*. And indeed, intergenerational trauma was a strong theme throughout our discussions with Island Health staff. As one participant stated, **"we have to appreciate how the impacts of intergenerational trauma are still very much [with us]—this isn't old history"** *[Adam Newton – Registered Social Worker]*, while another shared the importance of **"acknowledging the journey that we're all on"** and recognizing how **"generational trauma [...] really affects the individuals who have a lifetime of lived experiences"** *[Philip Friesen – Director of LTC Operations]*. Many staff reflected on

the effects of intergenerational trauma on Indigenous peoples, children and families, and the ways in which trauma fueled addiction later in life:

> **"I'm [...] learning about the truth and reconciliation [and] leaning into knowing more about generational trauma, and the effects that can have on people today, you know, all the way down their ancestry line [...] hearing those stories about people saying 'just get through, just stop drinking, or stop using' But [...] the journey through it [...] it's not easy"**
>
> *[Deidentified Participant]*

> "I know so many people who have issues with alcohol, but their parents were alcoholics and the grandparents. And it's really hard to break these cycles [...] it's really hard to break those generational things"
>
> *[Deidentified Participant]*

> **"There's deep trauma, generally, that falls behind addiction. [...] People look at people walking down the street, pushing a cart or sitting on a park bench asleep. And they judge. They have no idea what those people have gone through, what those people have endured their entire life that have put them to where they are because they had no other options. They didn't know how to numb themselves other than using drugs or drinking. And that is what we need to get to the root of, is why are these people hurting so bad and what can we do to help them"**
>
> *[Joleen LeChasseur – Admin Support]*

Indeed, while many staff reflected on the traumatic experiences of Peers, others discussed the impacts of such trauma on their jobs as health care workers:

> **"I think some things that really stuck out to me was [...] how [trauma] impacts the work that we do [...] and how we approach working with patients with, you know, possibly tough stories and experience."**
>
> *[Deidentified Participant]*

> **"[As health care workers, we need to] realize that [...] there may be traumatizing stories that we don't know about. If [Peers are] showing signs that [...] they don't want to be participating, maybe we need to stop and wonder what may be happening."**
>
> *[Deidentified Participant]*

> **"[Historical] decisions that have been made by people in many different industries, in many different levels of government, are kind of playing out in the crises that we see today. And it's easy for me to feel overwhelmed. It's easy for me to feel frustrated."**
>
> *[Deidentified Participant]*

It was clear from our discussions with staff that health workers often reflect on the historical and ongoing trauma that Peers experience, but they don't always know what to "do with" that information or understand what the best course of action might be. Some we spoke with, however, highlighted the importance of sharing with and educating staff and others around trauma, how it affects people's lives, and how it shapes the ability of staff to provide appropriate care for those who are hurting:

> **"So, I always like to educate and talk about [...] the trauma that's involved. And I always say people don't wake up with addictions. I really just want to work more with people on that and try to educate people about that."**
>
> *[Deidentified Participant]*

> **"...if you're not understanding the trauma that someone may have experienced, how can you provide appropriate care? I think that circles back around to the education piece: if we're not getting the education in some manner from the higher entities, I think that is a gap in being able to provide that trauma informed care."**
>
> *[Deidentified Participant]*

Staff that we spoke with provided important insights into the ways that trauma affects the lives of Peers and the care workers who interact with them. Staff shared how historical trauma shapes addiction and prevents people from forming real connections with others. Trauma was identified as an intergenerational force that has specific effects on Indigenous Peers and cascades through to affect children and families. Many staff felt unsure of the best ways to deal with structural trauma in their work but agreed that education and conversation were a good first step in forming front-line solutions to the crisis.

4.1.2 Stigma in society

Staff discussed stigma on two levels: as a societal force beyond the control of the individual, and as something that is experienced by Peers as they interact with staff in health care settings. In this section, we focus on the former structural discussion, as it is a source of frustration for staff and exists beyond the workplace. As one participant shared succinctly, **"there's still a lot of systemic barriers [...] I think there's more of it in the kind of general population, but it still infuses through the system"** *[Deidentified Participant]*. Indeed, many reflected on the ways that those in the general population weaponized their privilege and reproduced stigmatizing behaviour against Peers, sharing sentiments such as **"people are quite critical about the life choices people have made, but they didn't live their life, and they're not in their shoes [...] it has to stop, right?"** *[Deidentified Participant]*

> **"There's still a ton of [stigmatizing behaviour]. And I think it's really easy for people who haven't got relationships [...] with people who use substances, haven't sat with them, heard their stories, got a sense of why they ended up being where they are, it's really easy for them to make them 'the other'."**
>
> *[Deidentified Participant]*

"...if you're not understanding the trauma that someone may have experienced, how can you provide appropriate care? I think that circles back around to the education piece: if we're not getting the education in some manner from the higher entities, I think that is a gap in being able to provide that trauma informed care."

[Deidentified Participant]

Photo by: Caresse Nadeau

> **"I can hear echoes of [community] residents [talking] about the people who are homeless and being told to move on and stuff like that"**
>
> *[Kamla Gage]*

Some of the participants we spoke with provided us with powerful reflections on the effects of societal stigma and how stigma inhabits the bodies of Peers:

> **"I see it in kind of all walks of life [...] society put negative into them, and they started seeing it within themselves. [...] Just the negative impact of that thought pattern, and then feeling it into [themselves] [...] and acting [out] those attributes that are being forced on them."**
>
> *[Deidentified Participant]*

> "What stood out to me [was] trauma upon trauma, upon pain, upon stigma, and then numbness. And [when] people ask [Peers] "Well, why don't you get out of it?" And it's like, "we can't get out of it, because we're still in it."
>
> *[Deidentified Participant]*

Reflecting on their own stigma, and how it was passed on through society, one staff member noted that **"from where I came from drug addiction is a stigma, like just like any other mental health [issue]... I still have that sort of like prejudice in me, because I was raised that way"** *[Deidentified Participant]*.

Taken together, these quotes describe how Island Health employees recognize the stigma Peers experience from society at large, how that stigma affects the health of Peers, and how it shapes the attitudes of staff. Later in this report, in Section 4.3, we expand on these themes to show how stigma appears within health care facilities, and we outline strategies that are being employed to combat stigma in such settings. Next, we discuss staff's perceptions of the systemic housing crisis and the ways in which it is affecting their work and the lives of peers.

4.1.3 Housing

In addition to trauma and stigma, many staff pointed to the ongoing housing crisis in British Columbia and how it shapes their work and the lives of Peers. Some staff simply reflected on the enormity of the housing problem. One stated that they **"find it really hard seeing [homelessness], because [...] when the problem seems that big [...], it's really hard to know where to even start"** *[Deidentified Participant]*; while another found it **"really hard [...], driving by these folks who are struggling and feeling like nobody's doing anything about it,"** stating that, **"We're all just seeing and witnessing and accepting and it doesn't feel right"** *[Holly Anderson – Palliative Care Coordinator].*

> **"There is an exponential growth of people living on the street. In every small town of BC, and across Canada, there are more people falling through the cracks; similar to the 1930's. To me, this speaks so much about our economic system that penalizes people for poverty. End-stage Capitalism has no solutions for basic housing and basic integrity."**
>
> *[Sarah Sutmoller – Physical Therapist for Community Health Services]*

"I feel like it's a failure of our community if people are not housed [...] It breaks my heart that there's people sleeping outside, and it doesn't need to happen and they're dying.

[Maren Mclean – RN]

"We are at a point now where everybody's starting to talk [about homelessness] because it's much more visible to the general public [...] we're missing the mark, you know? But people [...] are seeing it, and [...] becoming more connected to the fact that this is [a] crisis."

[Nicole McAllister – RN]

Others reflected on how housing acts as a determinant of health, and how lack of housing can traumatize Peers and prevent them from being well:

"I think [...] housing is such a massive determinant of health, and people can't start to heal unless they have safety, and unless they have shelter [...] it's hard to really kind of focus on 'how do I heal,' when I'm just focusing on 'how do I stay safe?' [...] We've got these intersectional crises, and the housing is a huge one that I hear every day."

[Deidentified Participant]

"I'm seeing [...] a lot of barriers and divisions being put up between people in terms of housing and the unhoused. [...] I also see the lack of affordable housing for people and how that's just escalating [...] to the point where I think it really makes it hard for people to feel hopeful. And I think one of the main things that fuels addiction is that sense of there not being any point, that sense of hopelessness."

[Adam Newton – Registered Social Worker]

"I've thought, for a long time what the solution might be [to] housing [...]. I'm a little frustrated [...] when I see people being moved around being displaced [...] having their possessions taken from them, and thrown away as trash [...]. And we, as community members that are doing well [...] look on our homeless and our substance affected population as a 'problem' [and] don't give a lot of thought to [...] what people are suffering with and how deep that issue of trauma goes, right?"

[Deidentified Participant]

In their reflections, Island Health staff consistently highlighted the massive structural force of the housing crisis, the ways in which it affected them emotionally, and how lack of housing and homelessness

shaped the lives of Peers embroiled in the toxic drug poisoning crisis. Homelessness, while not an issue that is immediately solvable by staff members, was recognized as an upstream factor that affects their work. Later, we move beyond the structural issue of the housing crisis to look closer at what the organization might do to combat its effects.

In sum, in Section 4.1 we outlined three key structural factors of trauma, stigma, and housing that are influencing Island Health staff in their work and their interactions with Peers. Regarding trauma, staff shared the ways that intergenerational and historical trauma impacts the lives of Peers (particularly Indigenous Peers), children, and families, and shapes people's individual experiences with addiction. Others spoke of how stigma affects Peer health, as well as how it shapes staff attitudes toward Peers seeking care. Finally, many staff we spoke to mentioned visibility and the impacts of the housing crisis on Peers, and the intersections between the housing crisis and other societal crises that are raging. In the next section, we look more closely at how staff are feeling about their jobs in relation to the toxic drug poisoning crisis.

4.2 Working conditions and their impacts on Island Health staff

As we spoke with staff, many began to share some of the challenges that they faced at work, and how working conditions affected their lives, their interactions with Peers, and Peers' experiences in health care settings more broadly. These challenges can be broadly categorized under the intersectional themes of frustration, overworking, and understaffing. We present these themes together as they often overlapped within staff reflections.

Staff expressed frustration with many different aspects of their jobs relating to the toxic drug poisoning crisis. One of the main sources of frustration included Peers who repeatedly seek treatment in acute care settings, and who staff feel unable to treat effectively. One participant stated **"I see where the frustration comes in from people [around the crisis], and for the staff [that] see [the same people] quite a lot"** *[Deidentified Participant]*. Other staff members candidly shared:

> **"Because addiction is chronic in nature [...], people with Substance Use Disorders will come back to emergency rooms over and over again. You combine that with the frustration from frontline healthcare workers [...], that they cannot help the people who are seeking treatment [...], and sometimes I think the frustration of healthcare workers in their own feelings of powerlessness [...] comes out as hostility towards the person seeking treatment."**
>
> *[Adam Newton – Registered Social Worker]*

> **"I work on a lot of medicine floors, and we get a lot of patients coming in with addictions. A lot, a lot like too many. And a lot of them are like, again and again and again. [chokes up] I just think that we're failing them. I think like Island Health as a whole is, but then also we are as nurses... it's hard not to feel that way."**
>
> *[Deidentified Participant]*

Many noted how the combination of frustration and understaffing can result in poor experiences of care for Peers. As one person shared, staff frustration toward Peers **"perpetuates the impression [...] that the hospital is not a safe place"** *[Adam Newton – Registered Social Worker]*.

"There's not enough people on the ground, we are all spread so thin. So if you sit down in emerge or you work emergency, like the empathy and the compassion, a lot of our health workers have for vulnerable people [...] if we don't have the staff [...] then they have to send everyone back on the streets, because we just do not have the bodies to run that area."

[Deidentified Participant]

"I feel like it's so prevalent in what we're seeing [...] Because why are they coming back in? Especially [when] there's just not a lot of support. Like sometimes people will go days without seeing anyone from the addiction team or [...] community outreach programs [...] so then people just leave."

[Deidentified Participant]

"The one thing I've come up against is just the lack of time. So I think with Island Health in general [...] providers aren't taking the time for a humanistic approach to understanding the intersections that people face. [...] I think when you're dealing with healthcare providers, or nurses who are carrying caseloads that are too vast, even when they want to do a good job for people, they're not able to. And they're not able to spend the time that it actually takes to understand what that person might be experiencing when entering our healthcare system."

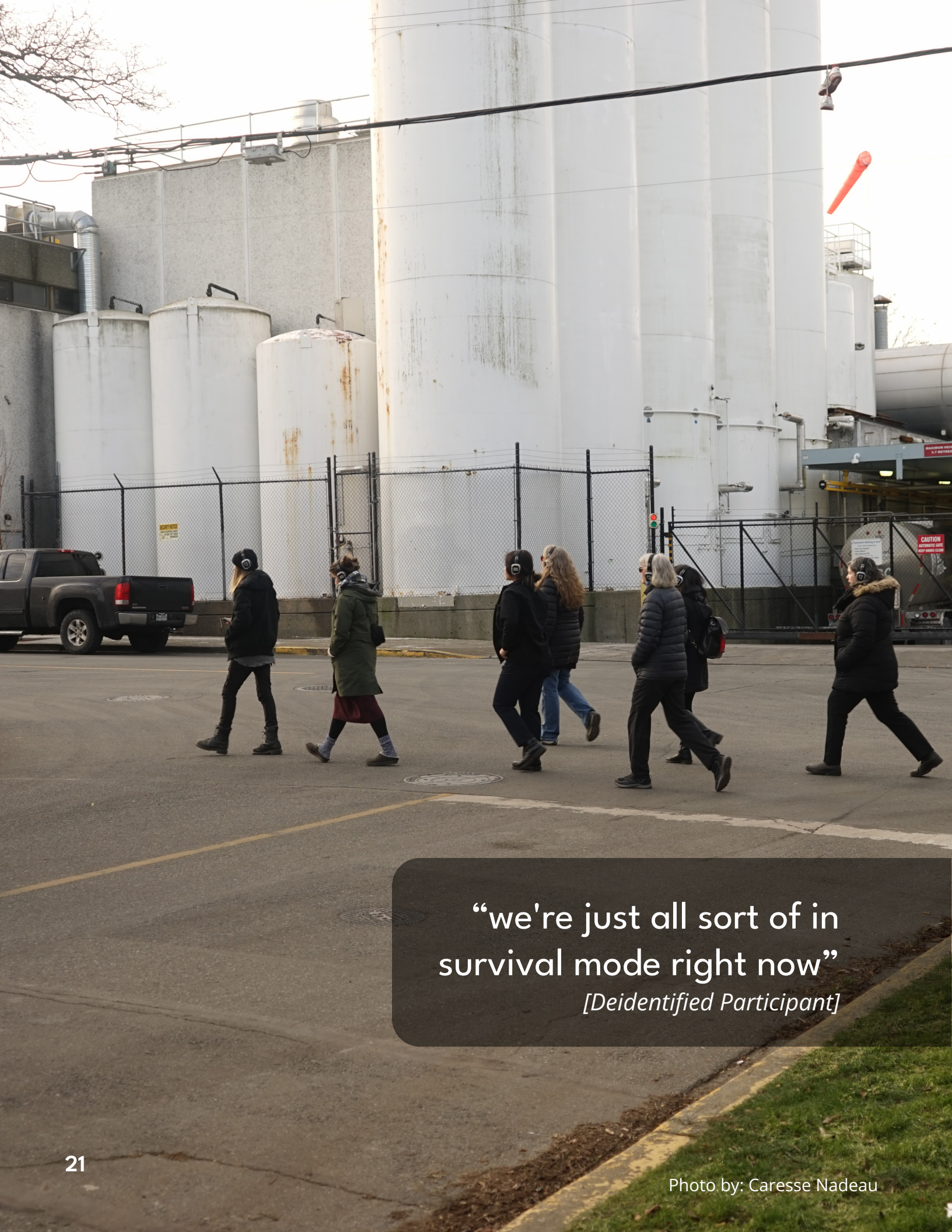
[MJ Harris – Registered Midwife, Medical Director Diversity, Equity and Inclusion]

Island Health staff also shared stories of overwork. As one stated succinctly, **"we're just all sort of in survival mode right now"** *[Deidentified Participant]*, while another noted:

> **"Island Health needs to do better [at] caring for our people. [...] We say self-care, self-care, self-care. You're burning everyone out, [...] just hemorrhaging people since COVID. Not just nurses, everyone, because we're out here pouring all of us into the people we want to help. [...] How can we care for others if we're not caring for ourselves? [...] If we don't start looking out for people that are on the ground [...] it's not going to make anything better for the public and the general community we serve."**
>
> *[Deidentified Participant]*

> **"You can't pour from an empty cup. You can't. And a lot of us feel like our cups are pretty empty. Unfortunately. It's sad to say, but I go home some days, and [...] I'm just mentally drained, and it's like that's all I can do for today."**
>
> *[Deidentified Participant]*

Finally, some pointed to a growing sense of apathy around the toxic drug poisoning crisis among staff, stemming from overwork and understaffing. As one staff member asked:



“we're just all sort of in survival mode right now”

[Deidentified Participant]

Photo by: Caresse Nadeau

"How do we help healthcare workers who are so busy and so taxed in the current system have a little bit of time, or energy, or opportunity to learn what's underneath the surface? [...] But I know that we're short, you know, nursing vacancy is high. And it's hard to imagine having five people [at an educational opportunity] and still have that unit be staffed. So it's, I think it's a challenge."

[Deidentified Participant]

"You see how the healthcare system kind of goes, [and] you feel defeated [...] You get jaded after a while, after you've been in it for so long. [If] I'm the only one giving my all, what is the point? So then you sit back and go, "Okay, well, why am I putting the extra energy in when nobody else is willing to do it, and I'm not getting anywhere."

[Deidentified Participant]

These reflections combined point to a dangerous trend in which some staff are so overworked they are unable to find time to care for themselves, let alone Peers seeking help from the medical system. Growing levels of frustration and burnout among staff, combined with the immensity of the toxic drug poisoning crisis, are creating a perfect storm within which Peers are caught up, with negative health consequences for all. While issues such as overwork and understaffing are often shaped by forces beyond individual health care sites, it is up to Island Health to take a proactive approach and ensure that staff have the emotional and financial resources available to deal with the immensity of the crisis. Individual staff are suffering, leaving them unable to effectively provide care.

In the next section, we build on the foundations set out in sections 4.1 and 4.2, drawing on staff insights to outline some of the different ways that harm reduction principles are being taken up within Island Health sites and departments as the organization responds to the toxic drug poisoning crisis.

4.3 Degrees of uptake

After walking and sitting in circle with Walk With Me, Island Health staff were invited to respond to the key research questions noted above. Responses were highly varied, but there are some specific observations about gaps and improvements in the system of care that were recurring. Of interest to us was the fact that the gaps identified by some staff were noted as improvements by others. This indicates to us that systems change is occurring, and that harm reduction principles are being taken up, but by degrees, with some Island Health sites and departments experiencing more (and different kinds of) transformation than others.

The following section includes nine themes, all of which describe defined areas in which gaps exist and improvements are occurring within Island Health's systemic response to the toxic drug poisoning crisis. These themes are: community building and collective reflection; cultural safety and Indigenous care; education; eliminating barriers; harm reduction policy and practice; increasing resources; meeting people where they are at; peer inclusion, leadership, and support; and reducing stigma.

4.3.1 Community building and collective reflection

One major recurring theme throughout our sessions included the need for building community and creating spaces for collective reflection in the face of crisis. Staff repeatedly gestured to societal

disconnection and spoke about the need for education and reconnection to make the situation better. As one noted, "this [is] a human crisis [...] a crisis about trauma, and a lack of community and connection" [Deidentified Participant], while others stated that:

> **"[There is] a loss of connection between neighbors and loss of community. And [...] what I'm seeing both personally and professionally [are] a lot of barriers and divisions being put up between people in terms of housing and the unhoused."**
>
> *[Adam Newton – Registered Social Worker]*

> **"I think that idea of community [...], it's that idea of people being our neighbors and that's [not] easy."**
>
> *[Heather Fox – Program Coordinator]*

Some respondents discussed what they do to build community, within their jobs at Island Health and beyond, in their personal lives. Staff members shared that:

> **"It doesn't take a lot of time to make a connection with a person, whether that's a colleague or a client or a patient [...] even if it's momentary community—how we can build those connections that might add up to two more, to feeling more welcome when you walk in the door? [...] I'm interested in how we can get more micro-moments of walking with other people."**
>
> *[Deidentified Participant]*

> "The biggest thing that's missing is that we're not all getting together and talking about what is going on [...]; until you've had that connection with somebody who's been through it [...], there's no push or drive to say 'I need to change this'. I think [those conversations are] what we're missing."
>
> *[Deidentified Participant]*

> **"Community is what gets us through. We work better as a team [...] than we do as individuals [...]. When we grow [...], we take those things into our workspaces, and our relationships. [...] I think as individuals, we can come together, do our bits and that becomes a greater whole."**
>
> *[Tracy McLeish-Schmit – Contracts Coordinator]*

One of our respondents asked the tough question: **"[Is] Island Health, treating people more as a transaction and less [as] community? [...] can we be more community based, and let people know that we're community based?"** *[Deidentified Participant]*. Other staff felt similarly, noting that care and support could be provided within Island Health clinical settings, but that the compassion stopped at the door, when it needed to be spread throughout society:

> **"I was thinking about this whole idea of community [...] we've kind of lost it in general. I feel like here [at work] we can be compassionate [...] we're paid to come in and be compassionate and be kind, but then we go home, and then the person is on their own again."**
>
> *[Deidentified Participant]*

> **"Not just healthcare providers, but everybody needs to be able to have the opportunity to build [...] compassion [...]. I would love to see this, not only within Island Health, but to become a societal norm, that we are building compassion [...] for every group of people so that we can build capacity [...] so that we can then go to action."**
>
> *[Nicole McAllister – RN]*

Some staff we spoke with were very interested in coming up with practical solutions to the crisis of connection, and brainstormed ways of building community that went beyond traditional health care praxis:

> **"I think wouldn't it be amazing if there was a database of Peer support that I can register on, and I could be connected [to] somebody who, you know, is living on the streets and is looking for help, looking for someone to talk to?"**
>
> *[Kamla Gage]*

> **"I would love to see the health authority work in partnership with the city and the unhoused community to come up with a much safer way to support people experiencing homelessness, rather than criminalizing and harming them."**
>
> *[Deidentified Participant]*

In response to the societal disconnection observed by staff, many discussed the need for collective reflection in the face of crisis. Many of these conversations were inflected by the presence of the Walk With Me team, and very likely mirrored the fact that participating staff had just participated in a story walk and were appreciating the value of collective reflection as they sat in circle. Participants stated that they were **"thankful to Island Health for all the learning programs that we have"** *[Deidentified Participant]* and were happy that **"the organization [is] open to these sorts of events so that we can grow as humans and individuals"** *[Tracy McLeish-Schmit – Contracts Coordinator]*. Others noted that walking together and listening to stories made them reflect on how **"we're all here together as humans trying to find our way and support each other"** *[Emma Isaac - Participant].*

> **"Island Health [...] allowing us to participate [...] I have to be grateful for that. [...] I'm going to commit to learning more."**
>
> *[Tina Nelson – Program Coordinator, Clinics]*

> **"One thing that Island Health is doing well is by providing opportunities for teams to be able to come to things like this. I think just kind of listening to where people are coming from."**
>
> *[Deidentified Participant]*

Staff also talked about the ways in which Island Health was already holding space for collective reflection. As one shared, we need to collectively reflect on the crisis and **"realize that we're all part of this group together"** *[Deidentified Participant]*, while another stated that **"coming together, talking, sharing stories [is] absolutely necessary—we need to reach a wider, broader audience"** *[Deidentified Participant]*. Another valued the "sense of community" that comes along with collective reflection, and learning **"what it means to connect with people on that human level"** *[Heather Strosher – Knowledge Broker]*, while another stated succinctly, **"having these conversations, that's how changes happen"** *[Amber - PIC PES SW]*. Other participants expanded on these ideas:

> **"I think making space for [human stories] is something I've seen already [...] here at Island Health so that policy changes can be made that are meaningful and reflect the actual needs of the populations being affected."**
>
> *[Karen Stewart-Kirk – Business Analyst]*

> **"I really appreciate times when we just stop [and reflect]; whether that's at the beginning of the day, or as a monthly thing, or whatever where [...] we stop and reflect and remember. [...] So that humanity, soul, deeper responsiveness, and responsibility is there [along with] the tasks of the day."**
>
> *[A.Fox - RN]*

> **"I think that there's some really good stuff happening [in Island Health], recognizing it's a process. [...] We just need to keep having these conversations and making sure that it's clear that [building connection] is a priority for the organization."**
>
> *[Deidentified Participant]*

For staff at one Island Health site in particular, collective reflection and action were cornerstones of their practice, and helped them combat disconnection. Staff at this site appreciated how they were able to work, talk, plan, and act together—as a team. As one stated, **"I'm super thankful for this team [where] people are like 'I don't know what's going on, but let's figure it out together'"** *[Deidentified Participant]*. Others at this site shared:

> **"I think one of the reasons our team is as strong as it is because of relationship. Having these challenging conversations are not easy [...] and being able to be with grief and sadness and fear and lack and racism and all of our struggles is so easy to turn away from, so [collective reflection allows us to] turn towards and accept the opportunity to make a change."**
>
> **[Katherine McDonald – Mental Health Clinician]**

> **"The times that I've seen where there's been success is when there's been community. [...] I see that at the place that I work at, the people I work with, that we build community with each other."**
>
> *[Deidentified Participant]*

But this kind of camaraderie was not evident in every site, and indeed, other staff expounded at length on the ways that the organization could do better in terms of creating spaces for collective reflection and supporting staff and communities affected by the toxic drug poisoning crisis. For some, this meant creating more opportunities for front line workers to come together, and even making collective conversations mandatory:

> **"I think that there could be more done to bring out [...] folks who are our frontline people, who are meeting the people who are seeking care [to collectively reflect]. [...] I think that there's room for growth and bigger opportunities."**
>
> *[Deidentified Participant]*

> "I think we can [...] make this a conversation that's front and foremost on everyone's minds. And having [collective reflection] like this be mandatory [...] Like we need to be doing more [to make sure everyone] has a basic understanding of some of these issues [...] and are essentially allies of the cause of trying to destigmatize and [...] make care more trauma informed and more culturally appropriate."
>
> *[Deidentified Participant]*

For others, the need for collective staff reflection stemmed from the fact staff were often siloed and detached from one another, and rarely had the time to slow down and connect around shared issues:

> **"I think that's a piece that I feel is missing [...] is that there's no integration between all these [Island Health] communities, those who work with the people, the people themselves, and then those up above."**
>
> *[Deidentified Participant]*

> **"Can we work on a program for care providers across the island [with space for] introspection? Because we all grew up in different cultures, with different perspectives. And we have discrimination and all kinds of things that we don't even realize that we have. Could we do a program [where] we just read and work on us?"**
>
> *[Deidentified Participant]*

Building on those themes, participants also shared how Island Health had a role to play not only in building connections and conversations between staff, but also with the broader communities that it serves:

> **"[In our working lives] we kind of forget how to take a step back and actually see where we are, where our clients are. [The] opposite of addiction [is] connection and that's where the community piece comes in again, so [collective action] has a huge impact when it comes to everything in life, but especially [the health care] field."**
>
> *[Deidentified Participant]*

"[In our working lives] we kind of forget how to take a step back and actually see where we are, where our clients are. [The] opposite of addiction [is] connection and that's where the community piece comes in again, so [collective action] has a huge impact when it comes to everything in life, but especially [the health care] field."

[Deidentified Participant]

Photo by: Caresse Nadeau

> **"The larger community needs to hear more. I want [these discussions] to be beyond just the circle of the people who are already invested [and] that's where I think Island Health has a role to play. They have a huge platform [and] they can reach every corner of this island. The provincial health authority [can] reach every corner of this province. [We need to be] using these tools to share information, share stories, share people's lives, get to know our neighbors, care about our neighbors."**
>
> *[Deidentified Participant]*

In sum, staff reflections indicated a notable concern regarding social disconnection. While some emphasized the importance of education and dialogue within and beyond Island Health settings, others proposed tangible measures such as outreach initiatives, peer support databases, and collaborations with external organizations to enhance social connection. Overall, the staff we interviewed recognized the significance of collective discussions, team building, and community engagement in addressing social isolation and other underlying issues fueling the toxic drug poisoning crisis. They advocated for the expansion of current programs and the establishment of additional avenues for fostering connection, building consensus, and collective action.

4.3.2 Cultural safety and Indigenous care

Our respondents also spoke about the importance of cultural safety and Indigenous care in relation to the toxic drug poisoning crisis. Many that we spoke to shared how the health authority was becoming more attentive to issues of cultural safety, and applauded the efforts that were being made in this regard—even as they acknowledged that improvement was still needed. Cultural safety, according to Island Health, is **"recognizing, gaining knowledge, and respecting the differences in each individual [...] listening and learning together in a way that maintains personal dignity [and an] authentic relationship of trust, respect, and collaboration [...] to ensure better access to health care services, improved health outcomes, and healthier working relationships."** Cultural safety in Island Health is **"committed to decreasing health disparities for Indigenous peoples, by increasing access to health care for Indigenous peoples."**[44] Regarding Island Health successes, some staff shared about specific practices they or Island Health were taking on to advance cultural safety:

> **"[In my role] I look at the spiritual and emotional parts of the person [...]: what gives them the strength, what matters to them. And [...] in Island Health, there are a lot of workers from a lot of different disciplines who tend to those spiritual needs at a very human level [...]; there's a trauma informed practice lens that is becoming more well known, and people are getting trained in cultural safety."**
>
> *[Marysia Riverin – Spiritual Health Practitioner]*

> **"I think that there's some really good stuff happening [in Island Health]. [...] We need [...] to keep pushing the momentum and bringing more people together [...]; in terms of our contracting processes, putting in language that is trauma informed and culturally safe. [...] We just need to keep having these conversations and making sure that [cultural safety] is a priority for the organization."**
>
> *[Deidentified Participant]*

"On the team that I work with, the management's been really focusing on cultural safety and learning, we've done like a blanket ceremony exercise [...] I feel like these things should be mandatory. And we've been talking a lot about truth and reconciliation, and I feel like 20 years ago, that never would have happened, it's really a good step in the right direction."

[Deidentified Participant]

Others spoke about the importance of the cultural safety education and training that they had received through Island Health:

> **"[It was only through my work in Island Health that I] became exposed to learning about Indigenous communities, the cultural safety [...] it was an advantage [to do] the education, that I was able to take the time to be able to do it. But not everyone's given that privilege and opportunity to develop that sense of awareness"**
>
> *[Deidentified Participant]*

> **"We get pretty great training [on] topics related to harm reduction, of trauma informed practice, the cultural training [...] which helps us to be steeped in recognition of intergenerational trauma, the importance of relationship building, the importance of the reality of mistrust towards health systems."**
>
> *[Deidentified Participant]*

> **"One thing that we're doing is a lot of training for volunteers around cultural safety, as well as harm reduction. And a lot of those training pieces are developed by people with that lived experience, which I think is, is so valuable."**
>
> *[Deidentified Participant]*

On the other hand, many that we spoke with still recognized a need for improved cultural safety training and awareness. As one shared, paradoxically, **"we are very harmful in some of our cultural safety in the care that we provide"** *[Charlene Devries – Manager, SPH]*, while others stated that **"[We need to have] a basic understanding of some of these issues at the very least, and [be] allies of the cause of trying to destigmatize and trying to make care more trauma informed and more culturally appropriate"** *[Deidentified Participant].* There was also a recognition among staff that cultural safety was not something that could be fully implemented overnight, rather it was an ongoing process:

"We have a long way to go [...]; there should be a lot of refreshers [on cultural safety], and more circles and talking about beliefs, values, practices, and culture, bringing this to the forefront of people's minds"

[Marysia Riverin – Spiritual Health Practitioner].

"The challenges that the communities face, are not [...] something that we can fix in a year or anything like that; I mean, this is work that we're going to need to do to support through generations. [And we're] taking some small steps now to try to do that."

[Deidentified Participant]

Many offered specific suggestions and practical solutions on how to embed cultural safety and Indigenous care practices into the work of the Health Authority. A number of these involved hiring more Indigenous Peers and spiritual practitioners, including setting up programs that would help people navigate Island Health's job application system:

"One thing that I see a lot that Island Health could do better, would be [...] to have some kind of an applicant navigator to help people that are [...] either Indigenous or homeless or have had like a difficult experience find the training they need to get entry level jobs, because it's like a daunting process to apply to work in the Health Authority."

[Deidentified Participant]

"I think we need more [spiritual practitioners] [...]. Nurses can't always be doing the emotional support or the relational support. Neither can social workers or other disciplines, because they have all these other tasks they have to get to...spiritual health practitioners are clinically trained to offer existential and psychospiritual interventions, with active listening and a compassionate presence"

[Marysia Riverin – Spiritual Health Practitioner]

"[An] Indigenous Patient Navigator who works in the emergency room is able to be there as a support person for Indigenous clients/patients who identify as Indigenous or Metis. So that's somebody who seems like an ally. [I want to] see a little bit more of that [...]: Island Health hiring people who are Indigenous or Metis who are providing more culturally safe treatment."

[Adam Newton – Registered Social Worker]

Others suggested creating welcoming spaces for people to practice culture and receive care in culturally appropriate ways:

"As a health care system, we actually have to do better and [...] offer people [...] the ability to... whether it's different spiritual practices, to be able to get health in the way they want. [...] And it's very paternalistic our healthcare system [...]; we tell people what we think is best [...], not asking the individual, not asking the family who is taking care of them, 'what do you actually want?'"

[Philip Friesen – Director of LTC Operations]

[Island Health needs to be] honouring the person for more than their biological self, more than the heartbeat. [...] Honouring each person within their traditions and their practices and culture. [...] Having drumming circles [...], [having a] gathering space where traditional practices can be honoured, like smudging, just really respecting all aspects of a person and who they are, I think will bring some of that healing and some of that care."

[Marysia Riverin – Spiritual Health Practitioner]

"I would really like to see a physical space in every Island Health location that's for our Indigenous populations; I would really like to see art up at every Island Health location. And I would like to see the Indigenous words that were extinguished brought forth."

[Deidentified Participant]

Overall, staff members recognized and appreciated that programs were being implemented and education was being provided to enhance cultural safety within Island Health, but they also expressed that there was much more that could be done in this regard. Cultural safety principles are being taken up by degrees, across sites and departments, and staff gave several practical recommendations on how uptake might be improved, including the hiring of Indigenous Peers, and creation of spaces within health care settings where cultural safety can be practiced.

4.3.3 Education

One of the most prevalent themes that emerged from conversations with staff included education. Staff spoke about education in relation to many different sub-themes, and told us how Island Health was doing well, or not-so-well, with suggestions for improvement—again indicating degrees of harm reduction uptake across sites and levels of the organization.

Staff that we spoke with were generally satisfied with the education that they had received from the health authority in relation to Indigenous issues, harm reduction, and the toxic drug poisoning crisis. Many staff expressed appreciation for all the education (and opportunities for education) that they had received as an employee, noting that they "have [the privilege] of working in an organization like Island Health [and getting] all this education" [Deidentified Participant], and stating that they've **"learned so much [about Indigenous issues] over the last couple years, especially working in Island Health [...]; we're quite committed to learning as much as we can"** *[Julita Traylen – Research Administrative Coordinator].*

"I think Island Health and certainly in our portfolio, there's lots of opportunity to explore and to learn [about harm reduction and Indigenous issues] [...] it's leading to better behaviors and policies and experiences."

[Heather Fox – Program Coordinator]

"[As a result of educational opportunities], I'm relearning history, because I wasn't taught in the right way. [...] I am on a personal learning journey to get the right facts. [Education] changes everything because we can hear about the [residential] schools and hear about what is happening, [and] really understand what it does on a personal level and to a family."

[Tina Nelson – Program Coordinator, Clinics]

Some staff shared about the in-person training opportunities that were being provided on the job, and how these "built in" experiences allowed them to learn about Indigenous issues, the toxic drug poisoning crisis, and people's lived and living experiences of the crisis:

"Things that we're doing well are new emergency rotations that have education days built in, so that we can actually increase capacity for staff, to build it in for them. [...] If I had a magic wand, I [would] be looking at just building [education] right into rotations because I think if we do address some of that we can go a long ways."

[Charlene Devries – Manager, SPH]

"We've recently talked to a lot of our long-term care staff about trauma and generational trauma and how it really affects the individuals who have a lifetime of lived experiences."

[Philip Friesen – Director of LTC Operations]

Finally, staff expressed appreciation for the online harm reduction training modules that were being provided for them.

"One thing I think Island Health is doing well right now [is that they have] introduced some mandatory courses on the toxic drug crisis. [...] I think that's good that [it's] been made mandatory."

[Adam Newton – Registered Social Worker]

"I do appreciate Island Health starting to do the education [...] We now have courses online for harm reduction that I believe should be mandatory for everyone to do."

[Deidentified Participant]

On the other hand, staff also noted some areas where educational efforts needed improvement along multiple lines, and some made concrete suggestions of how

and where improvements might occur. In general, many staff members shared that more harm reduction education in general would be valuable, stating that they **"would like to see more participation and more education go to every level of staff** *[Kristen Rea – Clinical Nurse Leader – SPU-LTC]*, and that **"educating our staff [on harm reduction] would be something small that we could do"** *[Deidentified Participant]*:

> **"[We need to] promote teaching and the education [to] provide a more welcoming environment [...]: a straightforward, kind of frontline solution."**
>
> *[Daniel Mains – Office Coordinator]*

> **"I think having more education would be helpful. I think having more storytelling and people with lived experience. Bringing it to the clinicians that are working on the ground to help humanize the experience."**
>
> *[Holly Anderson – Palliative Care Coordinator]*

> **"I think we just we need to provide more education to our staff on this, because the toxic drug crisis impacts all areas of health care, from acute care to community health to long term care. [...] There is a lot of stigma, there are a lot of prejudices. And the old thinking is still there of that addiction is a moral issue, not a medical issue or not a societal issue with lots of facets."**
>
> *[Adam Newton – Registered Social Worker]*

Others spoke more specifically around going beyond the online harm reduction modules and providing mandatory training that would help them in specific aspects of their front-line work:

> **"Harm reduction modules and things like that [are] a good first step. But for somebody who deals with certain populations, having [...] no training from Island Health to say 'this is the things you might expect' [and] 'these are things that you might feel,' [...] that's something that I would love to see a little bit more."**
>
> *[Jess Klem – Palliative Care Admin Suppor]*

> **"I would like to see [...] basic mandated education for staff onboarding [...] just so that people can come to their jobs at the hospital or in healthcare, with at least a basic understanding of how people make their way to the hospital with Substance Use Disorder, how people make their way to the streets, how complex all these issues are"**
>
> *[Deidentified Participant]*

> **"[We need] mandatory training for all staff on de-stigmatizing and trauma informed language, education on common street drug slang. [...] It is important for staff to understand the pharmacology in terms of the language a client is likely to use, as well as allowing the client to use language that is comfortable and safe for them while in a public space."**
>
> *[Deidentified Participant]*

Others spoke about promoting harm reduction and addictions education outside of the Island Health system to target families and children, as well as the public:

"I think having more education would be helpful. I think having more storytelling and people with lived experience. Bringing it to the clinicians that are working on the ground to help humanize the experience."

[Holly Anderson – Palliative Care Coordinator]

Photo by: Caresse Nadeau

> **"[Island Health could be] working with the education system [...] to allow more education to families and children and to try to stop [addiction] from happening in the first place, as opposed to dealing with it after all of it's happened."**
>
> *[Deidentified Participant]*

> **"I think trying to reach out to youth and just helping them and reaching the root so we can maybe tackle the trauma at a younger age."**
>
> *[Deidentified Participant]*

Finally, another participant spoke about the importance of training more medical personnel in general, in addition to providing subsidized education for people who wanted to be involved in the medical profession, stating that "if they're looking for a rehab assistant, they're all coming from the mainland, because there's no courses here on the Island" [Deidentified Participant].

> **"There's so many people who [...] don't make financially enough for going to school [...], it should be something that the health authorities are going in and saying, you know, we value you enough, we'll pay for that education, because they make nowhere near enough."**
>
> *[Deidentified Participant]*

Island Health staff that we spoke with saw great value in the educational opportunities that they had been given and advocated for the expansion of such programs to give more employees the chance to learn about harm reduction, trauma informed care, and the harms associated with the toxic drug poisoning crisis. Staff agreed that education was the first step towards creating broader solutions to the crisis, and wanted to see more on offer, even beyond the institution itself, to reach children, families, the public, and those who wanted to join the medical profession.

4.3.4 Eliminating Barriers

Another strong theme that came up in our circle conversations with staff included eliminating barriers—between Island Health departments, between workers and management, and between staff and the Peers that they serve. As one shared, **"I see a desire, a hope, a want from staff to do better [...]. There are these beautiful individuals in this place that really want to do positive work and positive change"** *[Marysia Riverin – Spiritual Health Practitioner]*, and many others agreed, noting that there is positive movement to remove barriers within Island Health. Many staff pointed to the positive role of management in supporting this work. One shared about their role as a mediator and bridge-builder between management and the Peers on the ground:

> "I'm privileged every day to hear what didn't go well for somebody in their care journey, and to hopefully bring those experiences and those stories back to leadership that can, in essence, as best they can, affect positive change."
>
> *[Kelly Suhan – Liason]*

Others spoke about the positive role of management in encouraging all staff to work together to solve problems and affect change in relation to the toxic drug poisoning crisis:

> **"I think with some new leadership happening and some new developments [...] being set up [it's] really going to help [...] bring the focus, attention, decision making, and momentum that [the toxic drug supply, harm reduction work] deserves."**
>
> *[Deidentified Participant]*

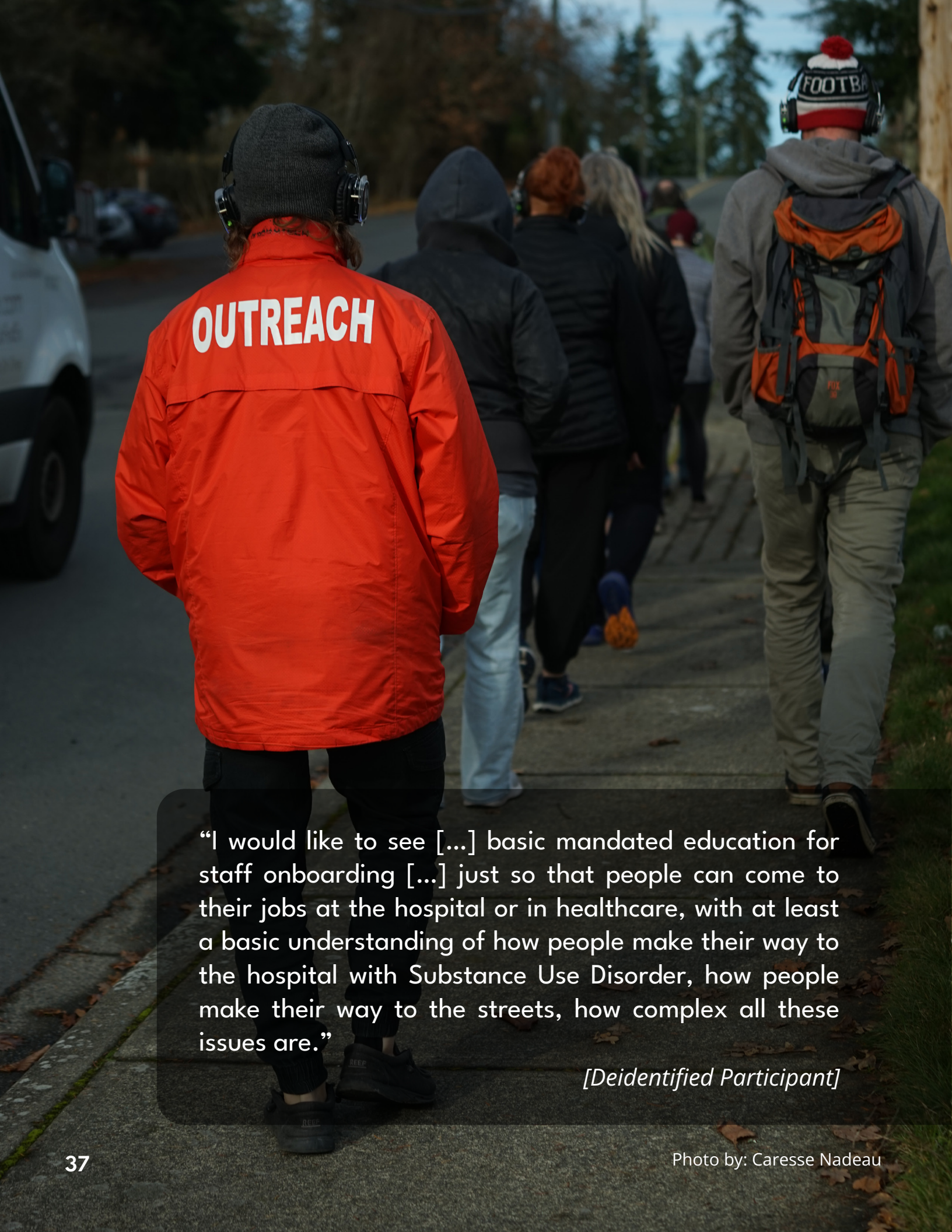
> **"I was at a meeting [with] patient and caregiver partners, our Peer support manager, and a bunch of our leaders [...] talking about various quality improvement initiatives that we're trying to initiate [...], getting feedback, making decisions together. And that comes from the top [...], our director made time and agreed that was a good thing to do."**
>
> *[Deidentified Participant]*

> **"I really appreciate [...] how management encourages us to get involved. And I know my management team is good at being supportive and [...] listening to us when we're challenged."**
>
> *[Deidentified Participant]*

One cited the Island Health Innovation lab as a catalyst for removing barriers and bringing disparate actors together to find creative solutions to the crisis:

> **I think the innovation lab is one of the things that Island Health is doing well and that can make a big difference in spaces like this. [...] This is a place that we can intervene, and we can do something. [We] put together a workshop [and] we got together people [from] different warming centres, different groups within Island Health who work with mental health and substance use, counselors [...] people with living and lived experience[.] We had people come together, and [...] facilitated conversations around 'what can we do?' and [...] we came up with [...] incredible ideas."**
>
> *[Deidentified Participant]*

However, these positive stories around innovation and supportive management were often overshadowed by talk of the acute barriers that existed between people, departments, and initiatives within Island Health, and between the health authority and those it serves. As one staff member stated succinctly, **"a piece that I feel is missing [...] is that there's no integration between all these communities, those who work with the people, the people themselves, and then those up above"** *[Deidentified Participant]*. Many spoke of the barriers that exist within the organization and how they needed to be overcome, with one participant stating that **"Island Health could do better at not working in silos"** *[Deidentified Participant]*.



"I would like to see [...] basic mandated education for staff onboarding [...] just so that people can come to their jobs at the hospital or in healthcare, with at least a basic understanding of how people make their way to the hospital with Substance Use Disorder, how people make their way to the streets, how complex all these issues are."

[Deidentified Participant]

Photo by: Caresse Nadeau

"In Island Health, the pockets of work aren't shared very well [...] I work with almost every single department in Island Health, but I don't know the pockets of work that are being done. So I think [we could] work with each other a little more closely to understand like, what work is happening and how, as individuals [and] as programs, we [can] support each other."

[Kelly Suhan – Liason]

Island Health [is] so big, and I think that the bigger things get, the more overwhelming they get, the less understandable they become. And so we need to align [...] initiatives [and make] sure that everyone's taking a piece of the puzzle, understanding how that piece aligns with the bigger picture [...] and making sure there isn't redundancy [...] within different projects and initiatives that are happening."

[Deidentified Participant]

Building on these internal concerns, however, was a larger set of feedback that spoke to the bureaucratic barriers in the organization that prevented staff from implementing creative ideas, providing adequate care for Peers, or serving people in the places they are most comfortable. Regarding creative/new ideas, one stated, **"I think it's pretty [...] tough [to make change] because I think Island Health is [...] governed by certain regulations in terms of what they're allowed to do"** *[Deidentified Participant]*. Others reflected:

"I [work] with volunteers [and] a lot of them bring in really great ideas and [are] inspired and creative, and a lot of times [...] we can't bring a lot of those [ideas] forward just because of the system that we're in. [...] There needs to be some higher-level changes to really make the impact."

[Deidentified Participant]

"It's [a] super bureaucratic system, like we want to do these changes, and there's people out there "but we can't, because of XYZ stopping us" [...] It just feels like a systemic change has to happen with [...] capacity for leaders to be able to think more freely."

[Deidentified Participant]

Regarding challenges in providing adequate care for Peers, others shared that:

"Some of the things that keep us well, are not compatible with hospital policy all the time, right? And so even when you think about how many people can you have in a room [...], some of those things that are really wellness for an individual just don't match with infection control, or... so many things."

[Deidentified Participant]

"We actually have to start being flexible, we have to start realizing that [...] if people can't access the health care system and don't know how to, that's where we actually we need to start doing better."

[Philip Friesen – Director of LTC Operations]

Finally, participants identified major bureaucratic challenges in providing care for Peers in the places that Peers felt comfortable:

> "[There are] barriers [around] where does our space end and the community space start? What can nurses do? How much can they do? [...] A lot of people come up with really good ideas, and then we're in such a colonial medicalized system [...]. We had one [person who wanted to] have a conversation outside [of our clinic] , and then [management said] 'workers comp, can't be outside, that's not safe.' So instead, you push [people] inside a clinic to sit in a room, in chairs [...]. And when you push it into a little medicalized room inside a clinic, it's a very different experience."
>
> *[Deidentified Participant]*

> **"Where [our clinic] is currently situated, we do have this green space that is right in front of us. And there's people there all the time. And I'm wondering [...] 'how can we reach out to this community instead of making us this very inhospitable clinic? [...] is there some way that we can [...] make it more hospitable and welcoming, as opposed to like, you can't come here unless you have an appointment?' [...] But then there's logistics of whether we're allowed to do that..."**
>
> *[Janice Mills – Social Worker]*

Work is being done at Island Health to eliminate different kinds of barriers within the health care system. Staff gave credit to the actors within management who were willing to overcome bureaucratic challenges, think creatively, and support them in their quest to provide better care for Peers. On the other hand, many shared about the barriers that still existed within Island Health, and between Island Health and Peers, noting how bureaucracy prevented people from exercising creativity, providing adequate care, and meeting people outside of the clinical setting. There is room for already successful initiatives to grow, but some bureaucratic procedures and risk management protocols may need to be reassessed before solutions can bloom.

4.3.5 Harm reduction policy and practice

One of the dimensions in which staff registered overwhelmingly positive feedback, and where they saw improvements happening, was in relation to harm reduction policy and practice, momentum which speaks positively to the implementation of Island Health's Harm Reduction – Substance Use policy. Staff shared that they **"have seen improvement [in Island Health] for sure. We've got our addiction medicine team [and] we've got**

a lot more harm reduction" *[Janice Mills – Social Worker]*, as well as more **"options in the treatment continuum"** *[Deidentified Participant]*. Some specifically pointed to the new Island Health Harm Reduction – Substance Use policy, as well as other ongoing initiatives, as catalysts for this positive change:

> **"I think the new Harm Reduction - Substance Use policy is really moving us in the right direction and there's a lot of beautiful things that could come from the guiding principles that are behind that and I hope it does reach through the system because in writing, in principle, it really is an exceptional policy."**
>
> *[Heather Strosher – Knowledge Broker]*

> **"As far as Island Health [goes], I have friends who work in harm reduction policy and supporting safe consumption sites [...]. I know there's good smart people trying hard. I truly believe that the organization is truly committed [to harm reduction]."**
>
> *[Sarah Gatschene – Manager CYF-RS]*

> **"So the drug testing services, the safe consumption, I know that safe opiate supply saves lives. So I feel honored and so happy that I am witnessing Island Health changing and providing these services [...] There is an urgency, we have people dying."**
>
> *[Kristen Rea – Clinical Nurse Leader – SPU-LTC]*

Staff appreciated the ways in which Island Health sites were transforming in response to the Harm Reduction – Substance Use Policy, and the openness of people to take on the work. Some expressed excitement at being able to do harm reduction work and provide care for those in urgent need:

> **"I think there is so much openness at [my] site to do the [harm reduction] work, to do the work well, and to really tactically think about how [we are] set up to care for folks. So that they stay here and get what they need, and don't need to leave, and don't feel pushed out, and don't feel turned away."**
>
> *[Deidentified Participant]*

> **"[Where I work] we're starting to implement more of a harm reduction approach, which has just been so needed because prior to that, it was all like abstinence, abstinence, we don't talk about it."**
>
> *[Deidentified Participant]*

> "I'm lucky that I can prepare and provide harm reduction supplies, safer smoking, safer inhalation kits [...]. We're happy to provide information and education about the supplies, [...] I love handing out and creating the supplies [...], I'll see a little bit of supplies go and I'll top it off."
>
> *[Daniel Mains – Office Coordinator]*

While only some staff explicitly discussed Island Health harm reduction policies and practices, those who did were highly appreciative of the initiatives that were taking place and were excited to do the work. On the other hand, and as we will show next, staff did highlight the need for Island Health to increase resources to expand harm reduction initiatives and address the toxic drug poisoning crisis head on, highlighting again that harm reduction policies are being taken up by degrees, and with respect to different needs, across sites and departments.

4.3.6 Increasing resources

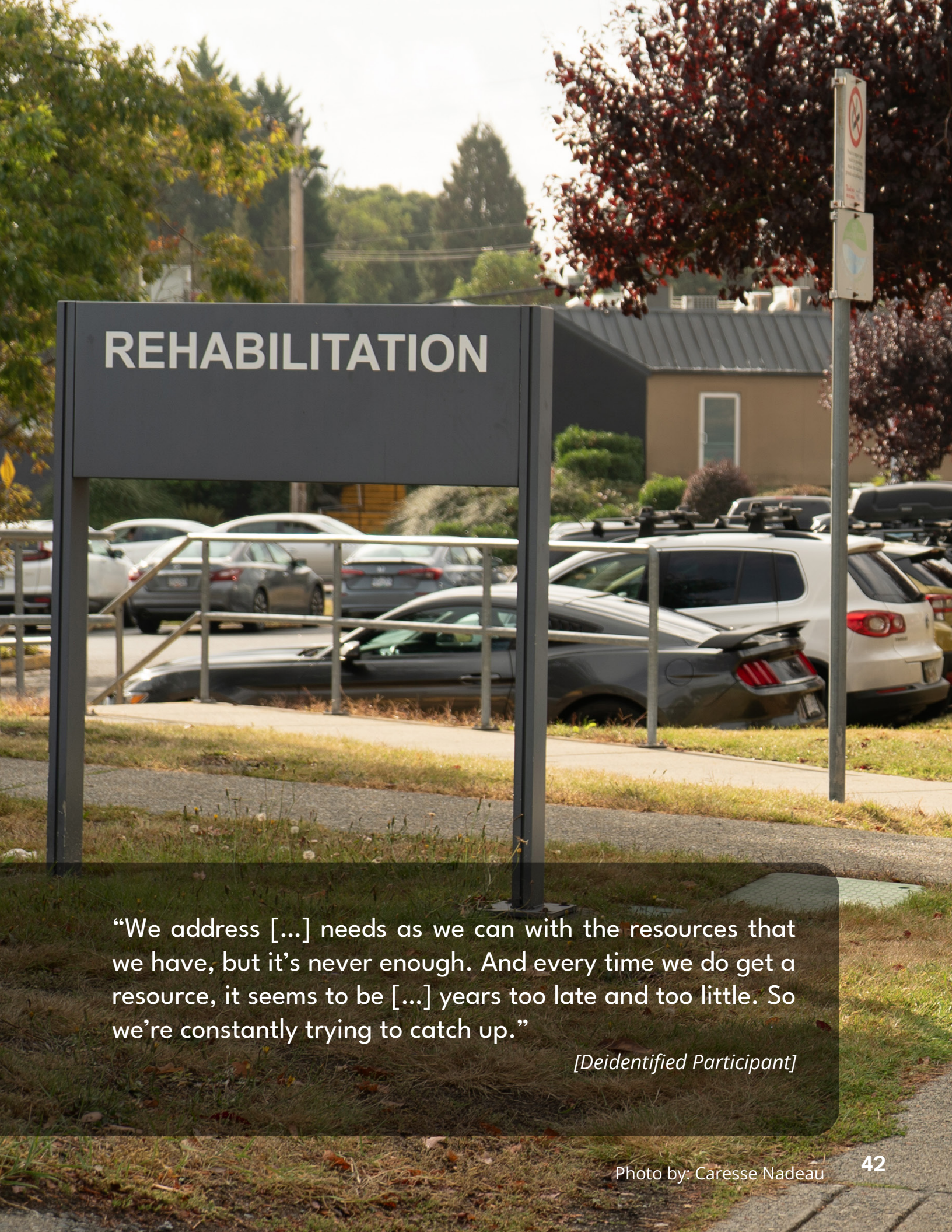
While many staff were appreciative of the various harm reduction policies and initiatives taking place at Island health, they were also insistent that more resources were needed in various areas to make sure that people can access the care they need, when they need it. Some spoke about the need to increase resources in general, while others spoke to more specific areas where resources can be targeted, such as safe supply, addictions services (treatment beds and recovery), housing, care in rural communities, and prevention. On the more general side, staff simply noted that they need more resources:

> **"I'd really like to see more resources put into place and more in a timely manner as well. [...] I can only do my best in the area that I work and try to advocate for my patients [...] But unfortunately, I go up against a much bigger system than I am."**
>
> *[Deidentified Participant]*

> **"We address [...] needs as we can with the resources that we have, but it's never enough. And every time we do get a resource, it seems to be [...] years too late and too little. So we're constantly trying to catch up."**
>
> *[Deidentified Participant]*

Beyond these general comments, many staff were specific about where they feel increased resources should be directed. Some spoke to the importance of having more resources put into safe supply programs for people who otherwise would access toxic substances, noting the challenges around how the existing program was working, with people being unable to access safe supply when they needed it. As one staff member shared, "... in theory, there's great ideas of how we can do safe supply and all of these things, but because it's done on such a micro level [...] the idea doesn't come to fruition in the way that it should" [Deidentified Participant]. Others stated:

> **"We've got a toxic drug supply crisis, as well as an addiction crisis and housing crisis. And I think until the powers that be start to have difficult conversations about the drug supply, and how do we make that supply as safe as possible and regain control of that supply [...] I think we're still kind of skirting the periphery of this issue..."**
>
> *[Deidentified Participant]*



"We address [...] needs as we can with the resources that we have, but it's never enough. And every time we do get a resource, it seems to be [...] years too late and too little. So we're constantly trying to catch up."

[Deidentified Participant]

Photo by: Caresse Nadeau

"I would love to see Island Health [...] advocate for a method to ensure people who need safe supply are able to access it. [...] The reality is people are dying because of toxic drugs. [...] Countless deaths could be prevented by simply providing people the medication that will prevent them from accessing toxic drugs on the street [...]. I do believe access to safer medicine can save lives."

[Deidentified Participant]

"I always hear talk of safe supply, and it seems elementary to me that safe supply is a no brainer, but it seems really, really difficult to navigate. [...] It doesn't make any sense to me [...] when we could be helping them with safe supply, with helping to move them beyond that dependence on drugs and alcohol."

[Ian Campbell - RN]

Similarly, a theme arose around the need for more resources to be put into addictions and mental health services, and in particular treatment beds and recovery. As one shared, **"I do think we need more actual dedicated treatment facilities [...]. I don't think there's enough [places] where it's easy to detox medically"** *[Deidentified Participant]*. Others spoke about the lack of services and resources, and the challenges of getting people into recovery:

"I just feel like we need way more focus on mental health. If there was more places for people to get help with that, I think there would be a lot less of what's going on with the drug crisis."

[Deidentified Participant]

"I think we need more treatment beds, more treatment facilities, and not mandated treatment. [...] I do think there's a lot of people who are thinking about changing, or who are ready to change, who want treatment and either the location is not convenient [...] or the cost is not accessible for them. Or there's just long wait lists that make people feel really discouraged."

[Adam Newton – Registered Social Worker]

Beyond just the need for addictions services, many staff noted that even if they can get people into recovery, there is often nowhere for them to go when they are discharged, making the whole process feel like an exercise in futility. As one asked, "where am I pushing [people] to? They have nowhere to go, they have nowhere to land. So what do we do?" [Deidentified Participant] Others shared similar sentiments:

"I would love to see an expansion of available beds at detox [...]; surely additional beds would help. However, I think the main problem is there are more people coming out of detox that need a safe, sober recovery environment than there are funded options."

[Deidentified Participant]

"I [was] talking about the discharge to homelessness, and risk [management] stopped me in my tracks and said, 'We don't say that though. We say 'care complete' and discharged from hospital.' But in my mind, I have to call a spade a spade [...] we're discharging to homelessness. [...] [And] how do you survive the streets? How do you survive [...] without using substances?"

[Deidentified Participant]

This idea of "discharge to homelessness" was common throughout our interviews, and many believed that there should be a stronger integration between the rehab/recovery system and the supportive housing system, as well as an expanded system of supportive housing, so that people can access the housing they need, when they need it. Many simply spoke of the need for more housing:

> **"[The] biggest thing [...] for me always is [...] the housing piece [...] because we actually don't have places to put people. [...] We don't have enough housing to go around to suit everybody and their specific needs..."**
>
> *[Deidentified Participant]*

> **"[We need] more [...] housing for these individuals [...]. Once individuals are housed, then they can start working on their goals, you know, once they have a roof above their head, a warm bed [...]. So definitely more housing for our folks who are experiencing homelessness would be ideal."**
>
> *[Deidentified Participant]*

> **"I've thought, for a long time [that] the solution might be housing, of course [...] when I see people being moved around, being displaced, having their possessions taken from them, and thrown away as trash when [...] these are their lives, this is what people live with."**
>
> *[Deidentified Participant]*

Others spoke of how Island Health should be taking a leadership role in providing housing, and in collaboration with other housing providers to ensure that people get a place to live:

> **"One of the things I've heard a lot in this job is that we don't do housing. And I think because housing is such a massive determinant of health [...] it's hard to focus on 'how do I heal?' when I'm just focusing on 'how do I stay safe?' [...] I would like to see Island Health lead by example and start to invest in more supportive housing, stabilization housing, just to give people a chance to get a short respite from the streets and start to think about where they go..."**
>
> *[Deidentified Participant]*

"We need more of Island Health and BC housing, buying up these old motels and stuff like that, that aren't being used. Any other facility that has lots of rooms, and transforming them into housing for people."

[Deidentified Participant]

Finally, some respondents spoke of how existing supportive housing systems could be improved:

"All supportive housing sites should have social workers and/or clinical counsellors available. It is clear that BC Housing is not providing adequate support to people in supportive housing. This is surely a complicated issue between ministries of the province, but someone must step up to the plate and provide the support that people actually need. Maybe this isn't the role of the health authority, but someone has to do it."

[Deidentified Participant]

Beyond housing, a few people talked about the lack of treatment options available in rural and remote areas, and asserted that more resources should be made available so that people do not have to leave their home communities in order to be able to access supports. One person noted the issue of people coming from all over the Island to one central detox location:

"I was at Clearview detox recently and over half the admitted people were from different communities on the Island. If a safe and sober recovery environment does not exist in a community that is funded, how can a person be expected to reintegrated safely? Addiction recovery is health care, it should be funded across all continuums."

[Deidentified Participant]

Others shared similar sentiments, noting the lack of services in the far north Island, and the specific effects on rural and Indigenous communities:

"We don't have an active [...] rehabilitation site or a mental health hospital [Between Campbell River and Port Hardy]. And I think that would be a big thing that [...] would help."

[Deidentified Participant]

"[We need a] better understanding of the rural communities we live in [...]: how are we serving that population that [...] doesn't have easy access to different clinics? [...] I just think there's just gaps that are there [...]: capacity for a lot of the physicians hasn't been there."

[Deidentified Participant]

"My heart goes out to the remote Indigenous communities, because there are lots of people who are not getting basic OT or PT services. Since there are not enough nurses or doctors in these communities to make the referrals, then there is also not enough Rehabilitation coverage. These Indigenous communities have to get medical equipment alone, without the support of professionals, which could cause more problems, rather than solving them. For example, a poorly fitted wheelchair can cause skin breakdown which can have significant medical impacts. We need to set up services with trust and consistency, so that people have continuity of care."

[Sarah Sutmoller – Physical Therapist for Community Health Services]

The final area in which staff saw a need for increased resources was around prevention, to ensure that people can avoid having to face issues with addictions in the first place. As one person shared, **"it's really tough when we have to wait until people lose everything to get them the help they need [...]; there's so much prevention that needs to happen..."** *[Deidentified Participant]*. Another spoke about how over time, their job had shifted away from prevention to being solely focused on crisis management, and they asked how prevention might once again be integrated into the work of Island Health:

> **"We are so stuck in crisis management. [...] And unfortunately, we haven't done a good job at prevention in the [...] years preceding where we're standing today. [...] How can we shift so that we're not doing this again, 60 years from now talking about crisis management? [In my job] I've moved very much from, a little bit of prevention, a lot of crisis work, to barely keeping up with the crises..."**
>
> *[Nicole McAllister – RN]*

By far, however, the most significant theme brought up by staff regarding increasing resources for prevention was around reaching younger generations and young parents before addictions issues and trauma take root:

> **"I see the problem with being reactive, as a health authority. Proactive would be reaching out to youth, proactive would be putting in housing..."**
>
> *[Deidentified Participant]*

> **"I think prevention [...] we need to be educating the younger generations, those that have systematic or family histories of things [...] give them guidance..."**
>
> *[Deidentified Participant]*

> **"Island Health could have programs to support better family development. Access to services and supports for young mothers [...] for fathers to learn about anger management, healthy coping strategies, parenting skills, childhood development, etc."**
>
> *[Deidentified Participant]*

Overall, staff saw a need for targeting and increasing resources in several key areas to address the toxic drug poisoning crisis head on. Themes emerged around safe supply, addictions services, housing, care in rural communities, and prevention. Importantly, staff did not see these kinds of interventions in isolation—they saw them as being intertwined and integrated, part of a holistic body of care that should wrap around people from early ages to meet them where they were at. This brings us to our next theme, in which staff discussed the importance of meeting people where they are at, giving some examples of how Island Health was doing well in this regard, while also recounting the myriad ways in which the health authority can do better.

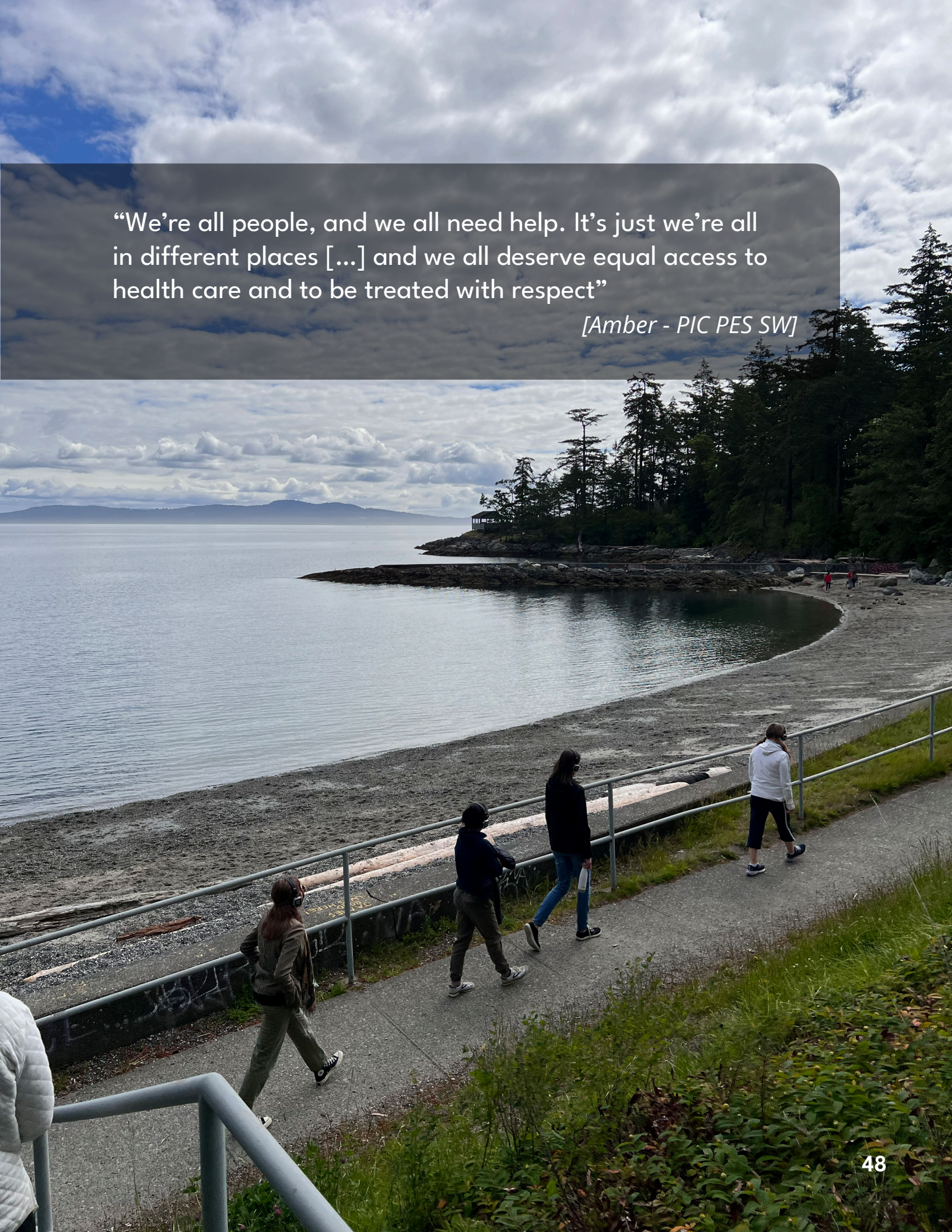
4.3.7 Meeting people "where they are at"

A strong theme that cemented in our conversations with Island Health staff included meeting people "where they are at." In essence, this term simply means health care staff engaging with people on their level, in a place where they feel comfortable, in a way that is respectful, and when they are receptive to interventions. Meeting people where they are at often stands in contrast with external expectations around wellness, recovery, abstinence, and stabilization, and focuses on what an individual needs at that time. As one person shared, **"we're all people, and we all need help. It's just we're all in different places [...] and we all deserve equal access to health care and to be treated with respect"** *[Amber - PIC PES SW]*. A few staff spoke of the positive effects that can happen when staff engage with people where they are at, and the need for more to be done:

> **"We don't know [...] about the past and somebody's lived experience. And so meeting somebody person to person and supporting them and meeting their needs, where they're at, I think is the way that we should be approaching most of the care that we're providing..."**
>
> *[Deidentified Participant]*

> **"One thing that Island Health is sort of waking up to that we're taking care of individuals with a lifetime of experiences, you know, negative and positive [...] we all live with different forms of trauma. And meeting people where they are [...] is something that we need to continue doing."**
>
> *[Philip Friesen – Director of LTC Operations]*

Many staff acknowledged the importance of engaging with Peers on their level, and recounted how they were already doing so, encouraging the organization to do even more. Yet others communicated that there was a lot of work to do to make this situation a reality:



"We're all people, and we all need help. It's just we're all in different places [...] and we all deserve equal access to health care and to be treated with respect"

[Amber - PIC PES SW]

"I feel like society really judges [people as being] worthy of support [...] when they experience addiction. And I think that something that we really have to work on is meeting people where they're at, [to give them] the chance to be one more thing [...] something more positive."

[Shannon Witham – Regional Harm Reduction Coordinator, Central Island Deidentified Participant]

"As a physician [...] there's a role that I can play [...] it's person care, it's community care, it's care for the person, so when they show up, and somebody calls them by their name and says, I'm glad to see you today. You know, how was your night? Or how did things go yesterday? I think that is how [we] as an organization [can] support community and not put barriers..."

[Deidentified Participant]

One expressed a particular urgency around making the effort, stating that **"somehow, we have to [...] find the human in people and to find the commonality"** *[Deidentified Participant]*. Another stated, **"everybody that I've met that is struggling has a very different need,"** asking, **"how can we be inviting [and] hold that space for them and just let them know they're safe there and that they're not just a transaction"** *[Deidentified Participant]*. Some staff expressed frustration around not having enough time or resources to be able to meet people where they are at, and provide patient-centred care:

"Providers aren't taking the time for a humanistic approach to understanding the intersections that people face. [...] And they're not able to spend the time that it actually takes to understand what that person might be experiencing when entering our healthcare system, that historically may have caused harm to them [...] that's what I think we need."

[MJ Harris – Registered Midwife, Medical Director Diversity, Equity and Inclusion]

Beyond acknowledging the importance of meeting people where they are at and the need for more time and resources, staff also had some ideas of how Island Health could do better at providing care for people in the places and at the times when they needed it. Many of these suggestions revolved around having patience, taking the time to make personal connections with people, and engaging in deep listening, to let people know that they care:

"Sometimes just listening is more than enough. We have patients come in [...], sometimes we listen to them for 15-20 minutes, and then [...] the patient is comfortable, they are ready to tell what's happening with them..."

[Deidentified Participant]

> **"What I find patients really appreciate, is when I'm witting with them [honouring] what they value, what has helped them cope in the past to get through difficult times, and simply helping through listening [...]. I would like to seeIsland Health have more staff, volunteers, or whoever – to come to just be with people and honour them as human."**
>
> *[Marysia Riverin – Spiritual Health Practitioner]*

> **"I think that we [need to] have more space for open-ended conversations and to some degree, flexible appointment schedules and such.... [When] I can spend an hour and a half with a patient if that's what is required, or more [...] I would love to see us be able to do a bit more of that."**
>
> *[Casey Petersen - RN]*

Throughout the course of our work, it was clear that Island Health staff recognized the importance of meeting people where they are at to break the stigma still prevalent in many health care settings. Yet those we spoke with also recognized the need for more to be done at the organization and site level, with many discussing the need for more time and resources to engage with patients and give them the care they need on their own terms.

4.3.8 Peer inclusion, leadership, and support

Related to meeting people "where they are at," many staff spoke of the importance of Peer inclusion, leadership, and support within Island Health sites. Some spoke to the positive initiatives that are already taking place in this regard, while others shared how the organization might improve.

It was clear from our conversations with staff that change is happening in Island Health in the realm of Peer leadership, to **"ensure that lived experience and people's human experience is included more in the decision making"** *[Heather Strosher – Knowledge Broker*]. Others noted that:

> **"Leadership [is taking steps] to meaningfully embed patient and caregiver engagement in decision making tables. [...] I feel really heartened by that. It feels like it's not tokenistic. It feels sincere, and we're so much richer for it."**
>
> *[Deidentified Participant]*

> **"I think that there are intentions to ensure that lived experience and people's human experience is included more in the decision making"**
>
> *[Heather Strosher – Knowledge Broker]*

Some spoke about the importance of having Peers integrated into clinical settings, to play a mediating role between health care providers and the Peers that they serve. One shared their appreciation for the **"teams [that] try to bridge the gap between the healthcare system and the [substance affected and unhoused population] as best as possible,"** *[Deidentified Participant]*, while another stated that the **"Indigenous support workers in our teams [...] teach us a lot day to day, when they connect with community"** *[Deidentified Participant].* Others agreed:

> **"[In some Island Health sites we]**

would actually have Peer support infrastructure team reports with our nurses and our physicians and our allied health, because they were part of the team. But they can provide a service that we could not. And it was [...] so well respected."

[Deidentified Participant]

"Peer support workers are very apparent in our hospital. And you can tell how meaningful their work [is] and how dedicated they are to their role [...]. [They] are incredible at [...] building that rapport with [Peers] to get them supported with treatment."

[Deidentified Participant]

"Seeing peer support in various settings, in like hospitals, rapid access addiction clinic [is] excellent to help build trust and relationships. [...] The more we can do in that regard, it just seems like a really good move."

[Deidentified Participant]

Some staff also spoke of the valuable role played by the Peer outreach teams that were connecting with people outside of clinical settings and meeting them where they were at, while also noting a need for more resources in this regard:

"It seems like the expansion of [...] outreach teams has been a move in the right direction where Island Health has invested money and resources into supporting people living with homelessness and substance use."

[Deidentified Participant]

"Many of the outreach teams that are that are walking around, I think they're going above and beyond really their capacity a lot of times [...] And we address those needs as we can with the resources that we have, but it's never enough."

[Deidentified Participant]

Many staff noted that there is room for improvement in terms of Peer support and involvement in health care. One shared the importance of integrating **"things like peer support, and the patients, and voices on our steering committees, and really looking at integrating feedback of all that lived experience into policy and guidelines and programs"** *[Charlene Devries – Manager, SPH].* Others shared how it needs to be easier for Peers to access services and supports:

"I get to hear [patient] experiences every single day [but] I don't get to hear experiences of those that aren't as privileged. We get a lot of conversation from folks [...] that have access to means of contacting us [and] fit into what healthcare has decided is the way that we access [...] systems and these support pieces. And not a lot of people have that privilege."

[Kelly Suhan – Liason]

Some staff recommended expanding peer support worker programs into clinical sites, even beyond those that dealt with mental health and substance use:

"I was thinking about [...] having

[peer voices] more embedded into a lot of the programs within Island Health. I just think that [Peer support workers] are so valuable [and could] help with capacity in different areas. We can use these people who have this lived experience to help."

[Deidentified Participant]

So at the door of each of our clinics [we could have] a peer support worker [...] standing in the entryway [...] meeting people where they're at... You just have somebody that everyone's comfortable with. And it's not a gatekeeper, it's a peer support worker."

[Philip Friesen – Director of LTC Operations]

Evidence from our conversations with staff across Vancouver Island suggests that people are noticing the important role being played by Peers at decision-making tables, as well as the vital role of Peer support workers and outreach teams in building bridges between crisis-affected communities and the formal health care system. Staff overall recommended that such programs be expanded and noted that more should be done to embed Peers into Island Health sites and teams as a way of stopping the stigma and addressing the toxic drug poisoning crisis head-on.

4.3.9 Reducing stigma in health care settings

Stigma against Peers accessing care remains a significant structural force affecting the health care system, affecting the types of care that Peers receive in clinical settings. We want to conclude our findings section by highlighting the voices of staff that spoke to the need for stigma reduction within Island Health. While some noted a positive trend where stigma was being reduced, others agreed that there is a long way to go and that improvements need to happen, again highlighting degrees of harm reduction uptake. On the positive side, one person shared that **"there's been a lot of good change [...] just as far as decreasing the stigma around addiction"** *[Deidentified Participant]*, while another noted that **"I just see improvements [and a] decrease in stigmatizing kind of behaviors on the floors"** *[Deidentified Participant]*. Another person shared the personal gratification that they receive from hearing Peers' positive reviews of clinical treatment, noting that **"when we go and see somebody and they say, 'I've been treated well here,' that's a good feeling"** *[Deidentified Participant]*.

A much larger set of interviewees, however, asserted that there are still significant issues around stigma in Island Health care settings:

"I think one of the biggest issues that we have here is the stigma piece [...] everyone that comes through our door should be treated with dignity. And sometimes that doesn't happen. Right down to asking them what they want. [When Peers] come in here, they're already worried about how they're going to be received. And unfortunately, sometimes [...] their fears are justified."

[Deidentified Participant]

"Something has to change, our

system is failing, and it is failing poorly. There is such a stigma behind addiction and drug use, and special populations. And [it's] just people that are not as lucky as all of us, that get to have a house, have a car, have a job."

[Joleen LeChasseur – Admin Support]

A couple of staff members offered some speculation on the reasons behind continuing stigma in clinical settings, one regarding unpredictable individuals, and one regarding a lack of resources to help people get the services they need:

"[Something] we struggle with and we haven't found the balance and the answers for yet is how do we manage our fear when we're dealing with folks with reactive behaviors, and in unpredictable situations, and ensure everybody's safety[?]"

[Deidentified Participant]

"[There is a] frustration from frontline healthcare workers, nurses, doctors, social workers, counselors [...] that they cannot help the people who are [...] seeking help to access [services that they need]. And sometimes I think the frustration of healthcare workers [is] their own feelings of powerlessness to help that person [and it] comes out as hostility towards the person seeking treatment."

[Adam Newton – Registered Social Worker]

Yet despite this, many that recognized the prevalence of stigma also recognized the need to reduce and eliminate it, pointing to strategies of non-judgement and patience as possible solutions to stigmatizing behaviours in clinical settings:

"I think what we can do better is [be] non-judgmental and reduce the stigma. [Everyone] has their own journey and experience [...] and we need to stop being so judgmental and [start] being open minded and hearted."

[Amber - PIC PES SW]

"We have to have patience. I think that can go a long way. That may mean understanding the challenges that people may face in being on time for appointments, [or] they may have a lot to say outside of the context of your engagement. There's a lot of stigma that people experience in feeling unheard, so I think just giving a little bit of extra time [and] space, to just listen [...] can go a long way."

[Deidentified Participant]

These strategies intersect strongly with discussions about staff education and meeting people where they are at, as highlighted in sections 4.3.3 and 4.3.7.

The perspectives of staff regarding stigma revealed a differential adoption of harm reduction principles with degrees of uptake, where some staff in some locations noticed that stigma was lessening over time at the site in which they worked, while also noting that the health authority had improvements to make in reducing and eliminating stigma in clinical settings at large, through patience, non-judgemental interactions, educational efforts, and simply meeting people where they are at. Stigma is being reduced, but there is still a long way to go.

4.4 Summary

In Chapter 4, we have outlined our research findings, showing the degrees of uptake of harm reduction principles across the Island Health organization relative to the toxic drug poisoning crisis. Based on our discussions with staff across multiple sites, change is happening along multiple fronts, yet there is much work to do.

In Section 4.1, Structural Barriers, we discussed some of the upstream issues affecting the crisis. These issues, which include those around trauma, stigma, and housing, affect Peers and the ways that they interact with the health care system. While such issues may have occurred long before someone's interaction with the health care system, and are often beyond the control of individual health care workers, they affect their lives and their work, including how they interact with Peers. In Section 4.2, we built on these insights to discuss Working Conditions and their Impacts on service delivery in relation the toxic drug poisoning crisis. We identified challenges here around frustration, overworking, and understaffing, which point to a trend where some staff are so overwhelmed and burnt out that they lack the emotional resources to provide care for themselves, let alone the vulnerable populations that they aim to serve. Such issues are acute and are hampering progress in addressing the crisis.

In Section 4.3, Degrees of uptake, we discussed some of the gradual transformations that are happening within the Island Health organization—the gaps that exist and the improvements that are occurring across sites and departments—along 9 interlocking themes. We first looked at the need for community building and collective reflection. Here, staff spoke of the importance of discussion spaces, team building exercises, and community engagement practices, as well as programs aimed at fostering connection, building consensus, and collective action in the face of the toxic drug poisoning crisis. Another theme identified was around cultural safety and Indigenous care, where staff recognized the tremendous work that is being done in this regard while making concrete recommendations around improvements, including the hiring of Indigenous Peers and implementing spaces for cultural safety in clinical settings. The theme of education was another that staff highlighted strongly. Staff appreciated the education programs that are already in place, but wanted more employees to have the chance to learn about topics such as harm reduction, trauma informed care, and the harms associated with the toxic drug poisoning crisis. They even spoke about the effects of education beyond the organization and wanted to see the health authority reach out beyond its walls to engage in educational initiatives with children, families, the public, and those who want to join the medical profession.

Another strong theme that came up was around eliminating barriers, particularly between departments in Island Health, between workers and management, and between staff and Peers. Staff acknowledged that much work has been, and is being, done to enable creative thinking, overcome bureaucracy, and support workers in their journey to provide care for Peers. But many barriers were still noted, particularly in relation to risk management, being able to think "outside the box," and meeting people outside of clinical settings. A related theme that we identified in staff responses included harm reduction policy and practice. Those who spoke to this theme pointed to the new Harm Reduction—Substance Use policy as a catalyst for positive change in the organization, and shared their appreciation around the ways that initiatives are being taken up to varying degrees, in place specific ways across sites and levels of the organization. It was clear that staff are

excited to do the work and put the Harm Reduction—Substance Use policy into practice, and they relish the opportunities that they have to do so. On the other hand, staff also recognized a need for increased resources to do this kind of work. Specific areas in which staff recognized a need for more resources include safe supply, addictions services, housing, care in rural and remote communities, and prevention. Moreover, staff recognized that interventions in these areas needed to be implemented in a holistic and interconnected way so that they can address the toxic drug poisoning crisis head on.

These insights were echoed strongly along the next theme, meeting people "where they are at." Here, staff spoke of the importance of engaging with people in a place where they feel comfortable, in a way that is respectful, on their level, and when they are receptive to interventions. Those we spoke with discussed the need for more to be done at the site and organizational level, and they called for more time and resources to engage with patients on their own terms. Staff acknowledged the difficulties of meeting people where they are at within a medical system often designed to do the opposite, but were adamant that doing so was important to break the stigma that many Peers still face. Relatedly, a strong theme emerged around peer inclusion, leadership, and support within Island Health sites, and many staff pointed to positive initiatives that were happening in this regard. They spoke of the importance of Peer outreach teams and support workers as bridge-builders between the health care system and affected communities, and recommended that such programs be expanded, with more being done to employ Peers within Island Health sites and teams to address the toxic drug poisoning crisis more effectively. Finally, staff discussed the continuing need for stigma reduction in clinical settings. There was a general feeling that stigma was decreasing over time, but that there was a long way to go. Our participants spoke to the need for patience, education, non-judgment, and meeting people where they are at as ways of further reducing stigma. In the next chapter, we draw on all these insights and offer a set of recommendations for actions that can further motivate systems change in Island Health.

5 RECOMMENDATIONS

Through our story walks, staff heard stories from those most affected by the toxic drug poisoning crisis, and afterward sat in circle to engage in deep reflection over the gravity of the crisis. Within these circles, staff provided insights and ideas for change, revealing degrees of harm reduction uptake across sites and within the organization as a whole, even as there is much left to be done within departments and at specific sites. Reflecting on these insights, we return to our two primary research questions:

- What is Island Health doing well to support those at the heart of the toxic drug poisoning crisis?

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

In asking these questions, we centred an intention to honour the improvements in harm reduction policy and practice that had been made within the organization since our initial report was released in 2022. see 3 We also wanted to understand which initiatives still need attention, and identify gaps that still needed to be filled.

Beyond the gathering of data, our research questions also point to accountability, namely, who is responsible for implementing the organizational changes to better address the toxic drug poisoning crisis? Systems change is a complex and ongoing process, and it cannot be performed by individuals acting alone—it needs many different actors throughout the organization, from leadership to frontline staff, to come together towards a common goal. Yet despite the need for everyone to work together, responsibility for change ultimately lies with the Island Health leadership who have the power to transform organizational values, challenge the status quo, and foment leadership and innovation potential within teams across sites. Such leadership can lead to important improvements in care for those affected by the crisis.

We want to reemphasize that these recommendations do not come directly from the Walk With Me team. Rather, they come from Island Health employees who participated in our walks at a variety of care sites across Vancouver Island. Recommendations emerged from the local contexts in which walks occurred, and they are particularly relevant and applicable in different ways across sites. Our hope is that those reading will consider these recommendations as motivation for continued transformation of the organization.

RECOMMENDATION 1: Address the multiple crises facing healthcare workers

Acknowledging:
That healthcare workers are facing multiple crises, including crises of overwork, loneliness, exhaustion, and frustration as well as mental health crises of their own, often hampering their ability to deliver compassionate care for Peers, we recommend that Island Health:

- Undertake a review of work and mental health conditions among staff across sites to better understand how such conditions are hampering meaningful progress in addressing the toxic drug poisoning crisis.

- Develop a strategy to support staff mental and physical health during the crisis, recognizing that staff stress and overwork often underlie negative encounters with Peers seeking care.

- Support hiring more staff to ease the workload of current workers, including Peer support staff and staff with training in cultural safety who can bridge between affected communities and frontline workers and reduce potential for negative, stigmatizing encounters.

- Reduce caseloads of existing staff.

RECOMMENDATION 2: Continue to pursue strategies to reduce and eliminate stigma within Island Health facilities

Acknowledging:
The progress that has been made to reduce stigma around the toxic drug poisoning crisis within Island Health, as well as the fact that people who use substances continue to encounter a culture of stigma within health care facilities, we recommend that Island Health:

- Engage with Peers, Peer allies, and staff in a program of deep listening and evaluation of current educational and professional development programs to encourage and support the de-stigmatization initiatives that are working: identify in which departments and sites stigma still exists and where interventions need to be targeted.

- Expand anti-stigma educational programs to better include the frontline workers who encounter Peers most frequently.

- Expand programs of Peer leadership within the institution and continue to employ and empower Peers as bridge-builders between staff and people who use substances within clinical and emergency care settings.

RECOMMENDATION 3: Make more space for innovation and creative initiatives

Acknowledging
The innovative initiatives and progressive policies that have already been put in place, as well as the barriers that remain which prevent the implementation of innovative solutions to the toxic drug poisoning crisis, we recommend that Island Health:

- Foster a culture of openness to new ideas.
- Provide management and frontline workers with the financial and educational resources to make innovative programs happen.
- Interrogate the risk management protocols, rigid regulations, and systemic barriers that hinder implementation of creative initiatives.

RECOMMENDATION 4: Improve communication and collaboration through inter-site mentorship and an online knowledge service hub

Acknowledging
The need for a robust collective response to the toxic drug poisoning crisis, and the need for effective, collaborative communication between Island Health sites and departments, as well as community service providers, we recommend that Island Health:

- Identify sites that are excelling in specific areas and create lines of communication and interaction where these successful sites can mentor others which are struggling.
- Promoting the organization's Harm Reduction – Substance Use resources intranet widely within and across Island Health teams and departments, and developing the intranet's capacity for knowledge exchange across departments and sites.

- Connect the online knowledge hub to physical service hubs in communities, where health and community services are integrated in a "one stop" service site for Peers (see Recommendation 8).

RECOMMENDATION 5: Continue to enhance the role of Peers within Island Health

Acknowledging
The deep importance of Peer leadership and voices in educating staff, generating systems change and developing creative initiatives, recognizing those which have already been implemented and the gains that have already been made, we recommend that Island Health;

- Review and evaluate existing Peer leadership inclusion strategies in Island Health to assess gaps and strengths in the current system.

- Continue to expand the role of Peer leaders within sites across Island Health, particularly in emergency departments and in leadership roles where they can create a welcoming environment and help other Peers access care and navigate institutional protocols.

- Further integrate Indigenous Peer navigators and cultural safety practitioners into health care settings to ensure cultural support is available for Indigenous Peers accessing care.

- Develop peer cultural leadership and education initiatives and create designated culturally safe spaces across sites.

RECOMMENDATION 6: Continue to strengthen cultural safety for Indigenous Peers

Acknowledging
The need to improve existing supports for Indigenous Peers who have experienced loss of community through the trauma of residential schools and ongoing colonial oppression, we recommend that Island Health:

- Further integrate Indigenous Peer navigators and cultural safety practitioners into health care settings to ensure cultural support is available for Indigenous Peers accessing care.

- Develop Peer cultural leadership and education initiatives.
- Create designated culturally safe spaces across sites where Indigenous

RECOMMENDATION 7: Address and manage the tension between collective/individual and biomedical/community-led responses to the toxic drug poisoning crisis

Peers can receive care from cultural safety practitioners and engage in traditional healing practices.

Acknowledging

The ongoing difficulty of meeting Peers "where they are at" and generating an effective, holistic community response to the toxic drug poisoning crisis in a system where healthcare provider engagements with Peers are often individual, impersonal, and transactional, and where Peer needs are often at odds with organizational goals around efficiency, we recommend that Island Health:

- Consult with Peers to find an effective community response that addresses people's needs collectively and holistically in place.
- Investigate possibilities for providing services and meeting with Peers outside of clinical sites, in places where they feel comfortable, to meet Peers where they are at.

RECOMMENDATION 8: Halt the "discharge to homelessness" cycle and shore up gaps in the continuum of care

Investigate options for flexible appointment times to provide care for Peers who have difficulty keeping appointments, or who need longer appointment times.

Acknowledging

The frustration felt by many staff as they release Peers from care without adequate

housing or wraparound supports, and the continued need for stronger, more diverse and more connected services for Peers across communities, we recommend Island Health:

- Seek strategic partnerships with agencies such as BC Housing and other non-profit housing providers to fund housing projects and create more streamlined pathways to housing for Peers, to ensure Peers can access safe shelter and adequate services when and where they need it without being left homeless.

- Work with Peers and staff across communities to understand and resolve the service gaps existing in places, recognizing the differences between communities. Such work could include service gaps and strengths analyses and planning processes in each community to strengthen the continuum of care.

- Work with service leaders across communities where Island Health operates to establish "service hubs" that connect clinical and community services and facilitate pathways to housing.

Together, these recommendations offer a suite of options for Island Health leadership and staff to follow in creating an increasingly robust response to the toxic drug poisoning crisis on Vancouver Island. We recognize and honour the work that has been done to date within sites and departments to take up harm reduction principles and respond to the crisis, even as there is more to accomplish. We advocate for place and department-specific responses that recognize the gravity of the crisis with respect to social and political differences between communities and levels of the organization. There is no silver bullet or one-size-fits-all solution to the crisis, and we call on Island Health to engage in deep listening with those affected to understand the specific needs of each community and department.

6 CONCLUSION

In this report, we have reviewed some of the key factors surrounding Island Health's response to the toxic drug poisoning crisis, which is also unfolding provincially and nationally. We have also examined some of the actions being taken by BC's provincial government and by Island Health to address the crisis. We acknowledge that despite these efforts, the number of deaths in the province due to toxic drug poisoning continues to climb, and that urgent actions are needed beyond current harm reduction initiatives to stop the fatalities and improve care for Peers directly impacted by the crisis.

The Walk With Me team has been honoured to sit in circle with Island Health staff from sites across Vancouver Island, and in our sessions we received many important insights that were given with the intent to create transformative change within the organization, for the benefit of those most impacted by the toxic drug poisoning crisis. Honouring the progress that has already taken place, we have consolidated staff insights into a series of findings and recommendations, aimed at Island Health leaders, that can be used to build new and modify existing frameworks for action.

As we close, we want to give respect to the land and to the Coast Salish, Nuu-chah-nulth and Kwakwaka'wakw people on whose traditional territories this work has taken place, and who have cared for this land since time immemorial. We honour and recognize all those who gave their voices to this process, and those we've walked alongside. We also honour the Island Health leadership who have supported this work and made room for this research within the organization with the intent to make change. By asking the difficult questions, and by looking at what is working/not working, change can happen, and new realities can be made possible.

APPENDIX A: BACKGROUND

A. 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 continues into the present.[45] In recent years BC has consistently shown the highest per-capita rates of apparent illicit drug toxicity deaths in comparison with other provinces.[46] Between 2016 and 2023, over 14,000 people died in BC as a result of the toxic drug poisoning crisis, and deaths for this period were substantially higher than unnatural deaths from other common causes, including suicide, motor vehicle incident, and homicide.[1] Over the course of the COVID-19 pandemic (2020–2022), the number of deaths in BC resulting from drug poisoning (6,352) was substantially higher than the number of deaths resulting from COVID-19 (4,806).[1,47]

The move to label the drug poisoning crisis a provincial emergency was a first in BC and Canada, and it triggered a multi-faceted intervention that aimed to save lives and reduce harm for people who use drugs. Elements of this intervention have included: public education, targeted information campaigns, connection with people with lived and living experience, increased access to treatment for Substance Use Disorder, distribution of naloxone to reverse drug poisonings, legislative changes, increased toxicological testing of drugs, expansion of harm reduction services (for example, establishing drug poisoning prevention services and expanding supervised consumption sites), the development of a ministry focused on mental health and addictions, and more. In 2019, the province claimed that such interventions had "averted 60 per cent of all possible drug poisoning deaths since the declaration of the public health emergency," and indeed that same year the province's illicit drug toxicity death number dropped significantly for the first time since 2012.[1,45(p3)] The 2019 death toll in B.C. showed a 37% reduction in comparison to the previous year—with total illicit toxicity deaths falling to 987 (2019) from 1,562 (2018).[1]

Yet despite these significant reductions in deaths, the onslaught of the COVID-19 pandemic appeared to counteract this reversal, with deaths nearly doubling in 2020 over 2019 and failing to decrease substantially since.[1] Numerous experts, including BC's former chief coroner Lisa Lapointe and the Public Health Agency of Canada, have identified the pandemic as having significantly exacerbated this provincial and national crisis.[48,49]

As recorded in the month of March, 2024 (the most recent month that data were available as of writing), British Columbia's unregulated illicit toxic drug supply is claiming the lives of an average of 6.2 people every day.[1] There are a multitude of long-lived harms to individuals, families, workers, institutions, and social systems that persist in association with these deaths. The magnitude of such harm is difficult to measure. These recorded deaths index significant pain for many connected to the deceased—as family members, friends and colleagues. The rising figures suggest immense risk for current illicit drug users and describe an increasingly heavy burden carried by health agencies providing support to those at the heart of the crisis, including Island Health.

Increases in record-setting death rates are explained in part by the evolution of novel illicit drugs. Illicit drug producers are motivated to create ever more concentrated and inexpensive drugs that adapt to the in situ capacity of prohibition policies to detect, criminalize, and abolish illicit drug supply.[50] Over 2023, benzodiazepines appeared in 42.6% of all deaths from illicit drugs in BC, up from 29.4% in 2022.[1] Because benzodiazepines are not opioids, naloxone—which is designed to target and block the depressive reparatory effects of opioids—can prove less effective in mitigating drug poisoning fatalities. Benzodiazepines add significant new life-saving challenges for first responders. This adaptive complexity of the supply chain illustrates how prohibition-derived solutions based on social assumptions and stigma produce ever more-deadly results. As has always been the case under the constraints of prohibition, illicit drug supply and demand evolve at a faster rate than the existing toolkit can respond.[50] Prohibition-derived policies force Island Health workers to endure the predicted consequences of BC's toxic and poisoned drug supply.

B. Locating impact

Our understandings of the impacts of the toxic drug poisoning crisis are informed, and limited, by the data collected by the Province, Island Health, First Nations Health Authority, the BC Coroners Service, BC Centre for Disease Control, and other health, government, and community service agencies. In this sub-section, we review some of the key statistics emerging from the provincial emergency.

B1. Who is most impacted by the crisis?

Knowledge of who the crisis impacts most is important as it helps to shape public policy, systems change strategies, and community action. These are some of the key demographic findings emerging from the crisis to date:

- The crisis disproportionately impacts middle-aged men. To March 2024, 71% of those dying of drug poisoning in BC were between ages 30 and 59. Males accounted for 71% of those deaths.[1]
- The crisis disproportionately impacts Indigenous people. 17.5% of drug poisoning deaths in BC in 2023 were First Nations people, a significant number as First Nations represent 3.4% of the province's population.[51(p3)]
- Recognizing the crisis' disproportionate impact on men, Indigenous women are significantly represented in drug poisoning statistics. While the crisis at-large in B.C. disproportionately affects men, data from January 2024 shows that women experienced 36.4% of toxic drug poisoning events affecting First Nations, compared to 24.4% of women among other residents in B.C.[51(p4)]
- The crisis disproportionately impacts people who are unemployed, as well as people in the trades and transportation industries. A BC Coroner's Service study of 872 drug poisoning deaths in BC from 2016 & 2017 (the most recent available as of writing) shows that most people who experienced toxic events were unemployed (66%). Of those employed, 55% were employed in the trades and transport industry.[5(p5)]
- The crisis disproportionately impacts people who are grappling with pain and mental health issues. The same study shows 79% of drug poisoning death victims had contact with health services in the year preceding death (690/872). Over half (56%) had contact for pain-related issues (389/690). More than half of the cohort (455/872) (52%) were reported to have had a clinical diagnosis or anecdotal evidence of a mental health disorder.[5(p5)]

- Most drug poisoning victims live in private residences. The above-mentioned study from 2016 & 2017 shows 72% of drug poisoning victims as having lived (and experienced poisoning events) in private residences, 13% as having lived in social/supportive/single room occupancy (SRO) housing, and 9% as having lived unhoused.[5(p5)]
- Most drug poisoning victims are not married. 65% percent of those who had experienced drug toxicity in the study had never been married.[5(p5)]
- Most drug poisoning victims use drugs alone, rather than with other people. The majority of those who experienced a fatal drug poisoning event (69%) had used their drugs alone.[5(p5)]
- Fatal drug poisoning events increase during income assistance payment week. Recent BC Coroners Service data from 2023 shows the daily average of drug poisoning deaths in the province as having risen from 6.8 to 7.9 in the four days following income assistance payment day (Wed – Sun).[1]

These statistics help form a demographic profile of toxic drug poisoning victims that, though limited in scope, helps to inform understanding. From them, we understand this crisis as most severely impacting middle-aged men and Indigenous peoples, especially Indigenous women.

Indigenous peoples continue to be disproportionately impacted by drug toxicity related harms and deaths in British Columbia and more specifically in the Island Health Region. The conditions that inform Indigenous peoples' experience of addictions, mental health, and homeless are unique and profound, and they are rooted in colonial dispossession. They reflect the failed attempts of the British Crown and Canadian Government to systematically erase Indigenous agency, culture, and people while claiming and colonizing their land and way of life. During this state of emergency in British Columbia, First Nations continue to confront the consequences of colonization, the Residential School system, the Indian Act, and the countless racist and discriminatory policies and histories that inform their intergenerational trauma. Quoting BC's In Plain Sight report, "Widespread racism has long been known by many within the health care system, including those in positions of authority, and is widely acknowledged by many who work in the system."[40(p6)] It is critical to acknowledge these historical injustices have had in relation to Indigenous communities' experience of the crisis.

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

B2. Where is this crisis unfolding?

Contrary to public imagination and reputation, the crisis is not confined to large urban centres. For example, per capita, BC's highest per capita rates of death from toxic drug poisoning in 2023 were in the Northern Health Authority.[1(pp1)] Opioid use and overdose in small cities and towns is growing, and in some cases surpassing growth rates in large urban centres. According to a national study by Canadian Institute for Health Information with data from 2017, "opioid poisoning hospitalization rates in smaller communities were more than double those in Canada's largest cities."[52] Another report, produced as part of the BC Rural and Indigenous Overdose Action Exchange

shows that between 2016 and 2019, small and mid-sized BC communities "made up between 23-27% of all paramedic attended overdose events."[53(pp8)] A recent study by BC Emergency Health Services shows that although urban centres in BC witnessed the deadliest effects of the crisis in 2020, rural and remote areas also witnessed significant spikes in overdose calls to 911. Some of the highest increases in overdose calls were found on the BC coast and in small cities on Vancouver Island.[54,55] These statistics challenge the view that the overdose crisis resides in large urban centres.

B3. How is the toxic drug poisoning crisis unfolding in the Island Health region?

Between 2016 and 2023, Island Health recorded 2,329 illicit toxicity deaths, approximately the same number as Interior Health, third behind Vancouver Coastal and Fraser.[1]

At first glance, large urban centres may appear to be experiencing the worst of the crisis, however, when examining drug toxicity deaths as occurring as a per-capita rate (per 100,000 people), we see the highest illicit drug toxicity death rates in 2023 on Vancouver Island were to be found in Central Vancouver Island (67.1), then North Vancouver Island (62.8), and finally South Vancouver Island (38.3). A longer view from 2016 to the present shows that rates in Central and North Vancouver Island SDAs are rising, and have now nearly doubled the rate of the urban Victoria region.[1]

More specifically to the North Vancouver Island HSDA, toxic drug poisonings are concentrated in the Comox Valley Local Health Area (Comox Valley) and Greater Campbell River Local Health Area (Campbell River). In terms of number of deaths, 385 illicit drug toxicity deaths in total occurred in the North Island HSDA between 2016 and 2023, and we see the two communities, Comox Valley and Campbell River, as having similar numbers of poisonings (175 and 182, respectively) with Campbell River leading slightly.[1]

The data clearly demonstrates that the per-capita impact of the crisis is higher in the small cities of Campbell River, Courtenay/Comox, and in places like Nanaimo and Duncan, than in Victoria and its surrounding areas.[1] It follows that proportionally, the crisis is costing institutions and individuals far more outside of the capital region.

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

C. Key contributing factors

To date the toxic drug poisoning crisis has been fueled by a 'perfect storm' that includes an increase in toxic supply of drugs, over-prescription of opioid-based pain medication, increased criminalization of drugs, the COVID-19 Pandemic, and the rise, throughout western society and globally, in social dissonance factors such as unemployment, housing unaffordability and income disparity. These factors, coupled with ongoing stigma, racism, erosion of mental health supports, and erosion of education supports has fostered the toxic drug poisoning crisis.

C1. Increase in toxic supply

Fentanyl holds the lead role in driving the crisis. Fentanyl is a synthetic opioid that

is roughly 100 times more potent than morphine and 50 times more potent than heroin. It is legally used and distributed in pharmaceutical practice.[56] It is also made and distributed illegally through various supply channels. Illegal dealers order highly concentrated fentanyl online, and they receive packages from outside the country through mail or courier. Packages contain hyper-concentrated small quantities that can evade detection by the Canada Border Services Agency (CBSA) since the CBSA requires a supplier's permission to open packages weighing less than 30 grams.[57] Fentanyl traffickers range from organized crime operations to lone operators. Once the drug is in the country, it is diluted in clandestine labs, cut with fillers (such as powdered sugar, baby powder, or antihistamines), and mixed with other drugs such as heroin, or packed into pills which are often made to look like OxyContin.[58] 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."[58(para16)]

Toxicity in the supply of fentanyl stems from its frequent manufacture in unregulated sub-standard labs, its mixture with other toxic substances, and its high level of potency. Drug Toxicity Alerts issued by Health Authorities have become common in B.C.[59] It is often the case that a "bad batch" of fentanyl-containing drugs will move from a large urban centre outward into neighbouring small centres and beyond.[60,61] Over the past 13 years in BC, fentanyl has been detected in increasing numbers of apparent illicit drug toxicity deaths. While this rate stood at 5% in 2012, by 2023-24 it has increased to a staggering 85%.[1] Notably, when the US border was closed during the COVID-19 pandemic, drug supply chains were interrupted; this event resulted in an increase in drug toxicity.[62]

While more fentanyl is crossing into Canada and is linked to the rise in fatal drug poisoning events, new and even more dangerous illicit street drugs are also entering the scene including Carfentanil and W18, both of which are more powerful than fentanyl and carry a high risk of initiating a toxic drug event.[63] Methamphetamine use is also on the rise in B.C.'s supply—a stimulant that is regularly cut with fentanyl and other toxic substances.[64,65] At the same time, Benzodiazepines (commonly prescribed to treat anxiety and depression) are also being added to fentanyl and other illicit drugs and are associated with increasing numbers of toxic drug deaths.[65]

C2. Provision of safe(r) supply

In March 2020, BC's then-Minister of Mental Health and Addictions, Judy Darcy, announced new guidelines for prescribers aimed to support drug users with "safe supply."[66] These guidelines, which allow certain eligible populations of drug users to access prescription drugs from limited classes of health professionals, were designed in part to help stem the consequences of an increasingly toxic supply reaching the public during the pandemic.[67] In September 2020 these guidelines expanded under a public health order from provincial health officer Dr. Bonnie Henry to provide safe supply access to nearly all people who access the street drug supply.[68,69] The new guidelines also allow for registered nurses and psychiatric nurses to prescribe controlled substances. The roll out of this landmark initiative has encountered various "bottlenecks," namely under-resourcing and the challenge of construction of new protocols and systems, though delays were not unexpected as "B.C. [is] the first province or territory in Canada to pursue safer supply so aggressively."[68] BC's Ministry of Mental Health and Addictions has committed publicly to creating safe supply programs across the province—and indeed a 2023 review

of the province's safe supply program found evidence for the continuation of the program as part of a suite of options available to medical health professionals to address the toxic drug poisoning crisis.[9] At the same time, critics of safe supply have raised concerns around "diversion" of drugs by drug users and claimed that the program is making the problem worse, not better.[8] Such critiques have been soundly rebuffed by BC government officials, who have asserted that there is no evidence that safe supply programs have contributed to deaths from illicit drugs.[8,64]

C3. Opioid Agonist Therapy

Safe supply is in part an extension of Opioid Agonist Therapy (OAT)—a treatment strategy that has been in-place within B.C. since 1959. OAT involves prescription of opioid agonists such as methadone (Methadose) and buprenorphine (Suboxone), which are long-acting opioid drugs provided in daily doses used to replace shorter-acting opioids such as heroin, oxycodone, and fentanyl.[70(p444)] OAT is often considered the first line of treatment for Opioid Use Disorder. In BC, the College of Physicians and Surgeons of British Columbia (CPSBC) oversees OAT guidelines, tracks and monitors patients and physicians, and mandates the concurrent treatment of mental health and addictions.[70(p448)]

OAT reduces opioid-related morbidity and mortality, and this is increasingly so as synthetic opioids such as fentanyl become more dominant in the illicit drug supply.[10(p1)] A recent meta-analysis demonstrated that retention in OAT is associated with two to three times lower all-cause and toxic drug-related mortality in people with Opioid Use Disorder.[71(p2)] However, low quality OAT service provision prevents or slows uptake and retention.[72] Improved OAT delivery (that incorporates best practice guidelines) positively impacts uptake and retention of this service.[73] Recognizing the role OAT plays in preventing drug poisonings, the province needs to continue to systemically upgrade service delivery.

OAT—and by extension safe supply—roll-out happens differently in large urban centres than in small cities and rural locales. Best practice guidelines for OAT advocate for "continuity of care" between multidisciplinary teams of service providers, including "physicians, nurses, substance use counselors (with specific methadone expertise), social workers, probation officers, community mental health liaison workers, etc."[74(pp81-82)] Providing such wraparound support services in small communities that face shortages of health services and professionals is far more challenging than in large urban centres.[70(p446)]

Furthermore, OAT delivery in Canada is tied to contingency management strategies that allow patients to take their doses home with them as they stabilize. "Carry privileges" are increased "based on appointment attendance and consistently negative urine screens for opioids, stimulants, and other substances".[70(p447)] For OAT clients in rural and/or remote locations, transportation barriers disrupt regular access to OAT clinics and physicians, as well as to the wraparound services identified above. These same challenges facing systems of OAT provision are present in the rollout of safe supply. While leaders champion OAT and safe supply as strategies to counterbalance the rising toxicity of the street drug supply, their effectiveness is limited by numerous barriers, especially in rural and remote communities.

C4. Overprescription of opioid-based pain medication

Medical institutions feed opioid dependency through prescription. Canada ranks "second only to the US in per capita consumption of prescription opioids" as a nation.[14(para1)] This is in part due to a long-time laissez-faire approach to the prescription of pain

medication.[70(p446)] National clinical practice guidelines published during the early days of the crisis, in 2010 (the Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain), offered few parameters to prescribing physicians: "Many of the recommendations were nonspecific and almost all supported the prescribing of opioids; the guideline provided few suggestions about when not to prescribe."[75(pE659),76] Between 2010 and 2014, Opioid prescribing across Canada increased steadily by 24%, with 21.7 million prescriptions dispensed nationally in 2014.[70(p446)] This increase in prescription rates resulted in a "massive swell" in opioid dependency.[70(p446)]

Regulatory bodies have been working to come to terms with the damage associated with rising opioid dependency to address the crisis. The 2017 update to Canada's national clinical practice guidelines (Canadian Guideline for Effective Use of Opioids for Chronic Non-Cancer Pain) differs from its 2010 counterpart by introducing restrictive opioid prescription guidelines, including recommendations to enter into "opioid prescription modalities slowly, with short durations of use and a maximum dose."[52(p7),75,77] Other regulatory initiatives include reformulating long-lasting oxycodone into a "tamper-deterrent form" to address concerns related to misuse of OxyContin and developing and expanding provincial prescription monitoring programs with enhanced prescriber education.[52] The response has been fragmented as key elements of health regulations and policy are not provincially and nationally harmonized.[77(p1)]

Despite this fragmentation, government initiatives to restrict opioid prescription have been somewhat effective. From 2016 to 2017, the total quantity of opioids dispensed in Canada decreased by more than 10%, and the number of prescriptions for opioids fell by more than 400,000: the first decline seen since 2012.[78(p1)] However, by adding deterrents to opioid prescription practices, the measures also increased demand for toxic street supply, as regular opioid users were in many cases compelled to seek illicit supply from the street when denied pharmaceutical supply.[15]

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

C5 Criminalization

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

The Opium Act of 1908 was developed as part of a nation-wide attempt to control non-British immigrant populations, and today it still informs the legal framework for Canada's drug control policy, as well as alcohol, tobacco, and medicine regulations.[16,17] In 1911, the Opium and Drug Act added other opiates and cocaine to an expanded list of prohibited substances, followed by cannabis in 1923.[16] Bans on alcohol and tobacco consumption were repealed by most provinces during the 1920's.

In 1969 Pierre Trudeau's government ordered an investigation into drug law

reform. The resulting Commission of Inquiry into the Non-Medical Use of Drugs (also called the LeDain Commission) recommended the following in its final report to Cabinet in 1973: a repeal of the criminalization of cannabis, no increase in penalties for other drug offences, and in relation to those dependent on opioids, an emphasis on "treatment and medical management rather than criminal sanctions."[79(para3)] However, his government and those that followed into the first decade and a half of the 21st century advanced policies in direct opposition to this commission's recommendations.

The most recent and memorable government-led prohibitionist effort includes the War on Drugs. Shortly after U.S. President Ronald Reagan had popularized this call to arms and policy, in 1986 Canada's Prime Minister Brian Mulroney declared that "drug abuse has become an epidemic that undermines our economic as well as social fabric," a claim that was counter to both evidence and popular sentiment.[17(p123)] In 1987 the government announced the Action on Drug Abuse: Canada's Drug Strategy—which injected $210 million into the nation's fight against drugs.[16] A substantial portion of these funds were earmarked for enforcement.[80(p2)] In 1996, the Controlled Drugs and Substances Act was passed—a significant piece of legislation that further expanded prohibition.[16] Finally, in 2007, the Harper government released the National Anti-Drug Strategy, which removed the harm reduction pillar from the nation's drug strategy and emphasized "busting drug users [rather] than helping them."[19,81] This framework of increasingly prohibitionist legislation led to a situation in which drug arrests in Canada totaled over 90,500 in 2017, over 72% of which were for drug possession.[82(p1)]

The lasting rhetoric and propaganda of the War on Drugs has exacerbated Canada's drug issues. Its punitive approach to people who use substances produced the most severe penalties in the country's criminal code "surpassed only by offences such as assault or murder."[83(p65)] It allowed police "far broader enforcement powers in even a minor drug case than they have in a murder, arson, rape, or other serious criminal investigation."[84(p263)] Amplified penalties for drug possession and trafficking, coupled with an expansion of police enforcement powers, have contributed to the erosion of civil liberties and human rights in Canada, while criminal justice costs associated with substance use have increased—rising in 2017 to over $9 billion.[16,85,86]

Drug enforcement policy has never been applied to all citizens equally. Professor Todd Gordon traces the federal government's evolving drug laws and legislative frameworks throughout the 20th century and into the 21st as aligned with attempts to control non-British immigrant and racialized communities.[83] For Gordon, "Drug enforcement became an excuse for the police [...] to intervene in and assert their control in communities, on the streets, and in public spaces—regardless of whether those being targeted were actually violating drug laws."[83(p68)] Moreover, federal drug laws developed throughout the 20th century were "often based on moral judgments about specific groups of people and the drugs they were using (e.g. Asian immigrants who consumed opium)" rather than on "scientific assessments of their potential for harm."[87(p2)] Various studies since have demonstrated that these laws are still used to enforce systemic forms of anti-Black, anti-Indigenous and anti-immigrant racism.[88–90] While many factors influence the over-representation of visible minorities in the criminal justice system, Canada's punitive and the discriminatory application of drug laws play a substantial role.

Nations around the world began abandoning the War On Drugs in the

1990s as it contributed to human rights violations and the "spread of infections (e.g. HIV) [...] damaged environments and prisons filled with drug offenders convicted of simple possession."[16(para1)] By contrast, up until 2016/2017, Canada continued to develop and enforce prohibition-based drug laws; however, such laws were publicly, politically, and legally challenged during this time, and periodic allowances were granted. For example, in 2003 Health Canada granted a limited exemption from Canada's drug possession and trafficking laws under the Controlled Substances Act to the Vancouver Coastal Health Authority to allow it to open North America's first safe injection facility—InSite.[91] In 2016–17, Health Canada made subsequent efforts to allow for and streamline exemptions to the Controlled Drugs and Substances Act to permit overdose prevention sites (OPS).[92] These allowances, when positioned against the backdrop of over a century of prohibitionist legislation, appear as the first "trickles" in what has become a river of public and political pressure pushing towards decriminalization and legalization of personal possession of illicit substances.

The movement towards decriminalization began to pick up speed in 2016 when the Government of Canada announced a new Canadian Drugs and Substances Strategy in which harm reduction was re-instated as a major pillar of national drug policy.[19] In 2017 the Good Samaritan Drug Overdose Act became law, providing protection to people who witness drug poisoning events "so that they can seek help, and ultimately save lives."[93(para1)] In 2018 the Justin Trudeau government made cannabis legal for both recreational and medicinal purposes. Canada is the second country globally to accomplish this policy (after Uruguay) and the first G7 economy.[94] The 2021 development of Bill C-22—an Act to Amend the Criminal Code and the Controlled Drugs and Substances Act—was submitted for First Reading to the House of Commons on February 18, 2021, and has not yet completed Second Reading. Among other things, this bill aims to "repeal certain mandatory minimum penalties, allow for a greater use of conditional sentences and establish diversion measures for simple drug possession offences."[95]

These moves by the federal government towards an anti-prohibitionist stance towards unregulated substances mark a stark contrast to the staunch prohibitionist position taken by previous governments and by governments throughout the 20th Century and into the 21st. Yet positioned as they are against the backdrop of a crisis that has ravaged the nation, these steps are seen by many as too little, and too late.[96]

C6. Reluctance to decriminalize

In this report we define decriminalization to mean "personal use and possession of drugs is allowed, but production and sale is illegal."[87(p1)] Multiple sectors have asked federal government to do more and move faster in pursuit of decriminalization since 2016. Decriminalization as a policy reframes what has been constructed as a criminal justice issue and positions it as a matter of public health. Decriminalization embodies harm reduction, where people who use substances can access relevant services without encountering the criminal justice system and associated stigma. Under this framework, people found by police to be in position of amounts of illicit substances for personal use are supported with community resources rather than prosecuted.[87]
A small group of nations have successfully decriminalized illicit substances. Portugal, through its 2001 decriminalization policy has seen "dramatic drops in overdoses, HIV infection and drug-related crime."[97(para7)] People with Substance Use Disorder in Portugal are understood in society as patients rather than criminals, and they are connected with a web of social rehabilitation and health services. Alongside Portugal, Czechia, the Netherlands, and Switzerland

have also decriminalized drug possession for personal use and have invested in harm reduction strategies. The consensus arising from these models is that decriminalization is an effective tool in the toolbox for fighting the toxic drug poisoning crisis.[23,87,97]

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

2017 (November):
The Canadian Public Health Association report, *Decriminalization of Personal Use of Psychoactive Substances*, calls on the Federal Government to "Decriminalize the possession of small quantities of currently illegal psychoactive substances for personal use and provide summary conviction sentencing alternatives, including the use of absolute and conditional discharges."[98]

2019 (April):
BC's Medical Health Officer publishes the report, *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*, and again advocates for federal decriminalization of personal possession.[45]

2020 (July):
The Canadian Association of Chiefs of Police report, *Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing Special Purpose Committee on the Decriminalization of Illicit Drugs*, recognizes Substance Use Disorder as a public health issue, and identifies decriminalization for simple possession as an effective way to reduce the public health and safety harms associated with substance use.[99]

2020 (July):
BC's Premier John Horgan formally asks the federal government to decriminalize possession of illegal drugs for personal use.[100]

2020 (November):
Vancouver's City Council passes a motion to formally approach Health Canada in pursuit of a plan to municipally decriminalize the simple possession of drugs.[101,102]

2021 (October):

BC's Ministry of Mental Health and Addictions formally applies for a decriminalization exemption, meaning that adults can carry up to 2.5 grams of illicit substances on them without being criminalized.[20,88]

2023 (January):
Decriminalization of small amounts of unregulated substances takes effect for all of BC from January 31st, 2023 to January 31st, 2026.[20] While seen by many as a progressive move, others view this policy as so restrictive as to have little effect.

2024 (May):
Just over a year into the decriminalization pilot project, the Province of British Columbia and Premier David Eby, reacting to negative pressure from municipalities and the public around issues of crime, safety, and public disorder, asks Health Canada to amend the former exemption to exclude all public spaces, meaning that when called to a public space where "illegal and dangerous drug use is taking place" police will have discretionary power to move people along, confiscate substances, and arrest users. Private residences, shelters, OPS sites, and addiction service sites are still exempt.[103,104]

As a policy initiative, decriminalization represents a proven first step to address the toxic drug poisoning crisis, and current setbacks are disappointing. While decriminalization does little to address drug toxicity or ensure a safe supply of drugs for those who need them, it does free up significant resources in the law enforcement and court systems. Decriminalization treats substance use disorder as a health rather than a criminal justice issue and gives people pathways into the public health system where they might be able

to access resources and supports.[99,105] Despite endorsements for decriminalization from the Canadian Association of Chiefs of Police among many other knowledgeable bodies, local governments in BC have been weaponizing municipal bylaws in attempts to take the issue out of the provincial public health realm and into the realm of nuisance. Such bylaws seek to provide police and bylaw officers with new prohibition-based "tools" that they can use against drug users, essentially recriminalizing users at the local scale to advance stigmatization and punitive actions towards people who use drugs. Public frustration with open drug use, and the conflation of harm reduction and safe supply with decriminalization among some city councillors is fueling a retaliatory response against evidence-based policy and governance. This punitive municipal stance against decriminalization is placing some municipalities in direct conflict with provincial jurisdiction, leading to court challenges.[21,22,99,106] In addition, public opinion has currently shifted against decriminalization, even as toxic drug poisoning fatalities continue to increase. Governments, while having made progressive steps toward decriminalization, have been inconsistent in their policymaking, and have recently backtracked on certain aspects of decriminalization in response to public concerns around crime, safety, and public disorder. As of May 2024, decriminalization has now become much more limited in terms of the spaces in which it applies. While possession is still legal in private residences, shelters, OPSs, and at addiction service sites, Peers are now at risk of police intervention when in possession of substances in public spaces where possession was previously legal.[103,104]

Despite substantial setbacks, advocates are continuing to push the government for more substantial decriminalization measures. Some, such as the Canadian Drug Policy Coalition, are even advocating for steps beyond decriminalization and are calling for legalization of illicit substances—a move that would see some currently illegal substances regulated by the federal government in a similar fashion to cannabis, alcohol, and tobacco, making them subject to federal production and distribution laws.[107] Proponents of legalization tout its capacity, beyond that of decriminalization, to establish a system of "regulated purity," enforce age restrictions for sales, "prevent large racial disparities because of the wide discretion in charging by prosecutors," and disrupt "the enormous profits being made from drugs by violent criminal gangs."108 Some critique legalization for its potential to increase drug use and produce the harms associated with other regulated substances, such as alcohol and tobacco.[109] The argument in favour of legalization is difficult to test as currently there are no countries that have legalized hard drugs.

D. Upstream services – social determinants of health

Numerous upstream factors, such as lack of affordable housing, lack of access to quality mental health services, and lack of quality of education, are all exacerbating the crisis. These areas broadly represent the wages of hypercapitalism and modern social alienation. The subjects we touch on are by no means a definitive list but represent entry points for a systems-based understanding of the crisis.

D1. Housing

The correlation between the toxic drug poisoning crisis and lack of affordable housing is well established. In comparison to household income, house prices across Canada have grown rapidly in recent years—increasing 69.1% between 2007 and 2017, while median income increased by only 27.6% over the same period. Additionally, in the first quarter of 2019,

Canada's house price-to-income ratio was among the highest across member nations of the Organization for Economic Co-operation and Development.[110] While Vancouver and Toronto, as global cities, were "the first to catch the bug of extreme housing speculation," the crisis spread quickly to smaller cities and towns. "In British Columbia…it is not only Victoria and Kelowna feeling the heat, but [also] places like Nelson [and] the Gulf Islands."[111] In the Comox Valley, the benchmark price of a single family home was $833,600 as of May 2024, while in May of 2019, the benchmark price was $506,800, an increase of 164% in 5 years.112 In nearby Campbell River, the benchmark price of a single family home was $712,800 as of May 2024, and was $441,300 in May of 2018, a 162% increase.[112] Housing unaffordability is directly contributing to the exacerbation of health determinates, including homelessness, poverty, and addiction in North Vancouver Island.

"Housing First" is a policy approach that recognizes housing as the most important component in making progress on a multitude of social issues including those related to addiction. This approach has been successfully implemented in Helsinki, Finland, and in Medicine Hat, Canada (AB). As one of the key architects of the Helsinki program observes: "We decided to make the housing unconditional…to say, look, you don't need to solve your problems before you get a home. Instead, a home should be the secure foundation that makes it easier to solve your problems."[113] While the program may appear expensive up-front, it reduces costs related to emergency healthcare, social service, and the justice system, saving as much as €15,000 annually for each person provided with housing in the long run.[113] A similar program in Medicine Hat, introduced in 2009, has helped 995 adults and 328 children and led to significant progress indicated by "reductions in shelter use, the number of homeless housed and maintaining housing, as well as a number of measures introduced to restructure the homeless serving system."[114]

D2. Mental Health Services

In 2006, Rural B.C. was acknowledged to suffer from a "severe shortage of mental health services"—a reality recognized again ten years later.[115,116] A 2019 BC Coroners Report and a report from the Office of the Provincial Health Officer also confirmed this lack.[11,117] The Province in its 2021 budget committed to providing $500 million in new funding for "expanded mental health and substance use services," including $152 million for opioid addictions treatment—the largest increase in mental health in the Province's history.[118,119(para1)] In the 2023 budget, this funding was expanded, allocating approximately $1 billion for mental health and addictions, with over half of the funding slated to expand Indigenous treatment centres, innovate new treatment options, and provide more recovery beds throughout the province.[120] The 2024 budget has built on this investment, adding $214 million over three years to sustain existing mental health and substance use programs and harm reduction initiatives.[13] These increases in funding acknowledge the need to continue filling gaps in mental health service provision, and the link between mental health and the toxic drug crisis.

D3. Hypercapitalism and "Poverty of the Spirit"

Vancouver-based psychologist Bruce Alexander made headlines with his 2008 book *The Globalization of Addiction: A Study in Poverty of the Spirit*.[121] Before the toxic drug poisoning crisis in BC gained official status, Alexander posited that the rising proliferation of addiction throughout the 20th century would continue into the

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

Gabor Maté, a physician and well-known addictions specialist, makes a similar argument. Like Alexander, Maté argues that the roots of addiction lay in a wider societal context, stating that: "…illness in [a neoliberal, capitalist] society, […] is not an abnormality, but is actually a normal response to an abnormal culture…in the sense of a culture that does not meet human needs."[122] Addiction, mental health struggles, and many forms of physical and emotional distress are in this view a normal response to our failure as a society to acknowledge the consequences of late capitalism. Through a wider perspective, addiction appears as a coping mechanism and response to the absence of cultures of connectedness, belonging, and collective aspiration.

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

D4. Summary

In this Appendix, we have walked through key dimensions of the toxic drug poisoning crisis beginning with when it was labeled a provincial emergency in BC in 2016. Since then, there has been a dramatic statistical increase in toxic drug deaths nationally, provincially, and most importantly for this report, locally in the Island Health service delivery area. We have shown how this rise in fatal drug poisoning events has been shaped by the social determinants of health and processes of late capitalism, and has been fueled by several factors including: increased toxicity of supply brought about by a rise in fentanyl production and distribution, over-prescription of opioids followed by an absence of prescriptions

which drove many to the illegal market, the rise of the COVID-19 pandemic, and a regulatory environment rooted in a firmly prohibitionist stance. We looked at the slate of countermeasures that has been developed within Canada and BC to combat fatal drug poisoning events, such as the regulation of safe supply, the use of opioid agonist therapy, the establishment of OPS's, and the relaxation of federal and provincial drug legislation, among others. We also looked at the timeline of legislative and law enforcement actions that have occurred over the past few years under the banner of decriminalization, up until the current moment\, where possession and use of illegal sustances has essentially been "recriminalized" within public spaces in BC.

In this report, we have examined how Island Health staff are experiencing the crisis. These staff members possess a profound understanding of the situation, being deeply involved in it every day. They offer valuable insights into how the systems and cultural norms established by Island Health in response to the crisis can evolve to more effectively address the issue. We honor their bravery and contributions to our work. We hope this report will contribute to ongoing systemic changes within Island Health, helping us collectively make the toxic drug poisoning crisis a thing of the past.

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