APRIL 2018

Care not Corrections

Relieving the Opioid Crisis in Canada

CANADIAN MENTAL HEALTH ASSOCIATION

Canadian Mental Health Association
Mental health for all

100 *years of community*

Founded in 1918, the Canadian Mental Health Association (CMHA) is the most established, most extensive community mental health organization in Canada. Through a presence in more than 330 communities across every province, CMHA provides advocacy and resources that help to prevent mental health problems and illnesses, support recovery and resilience, and enable all Canadians to flourish and thrive.

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INTRODUCTION:

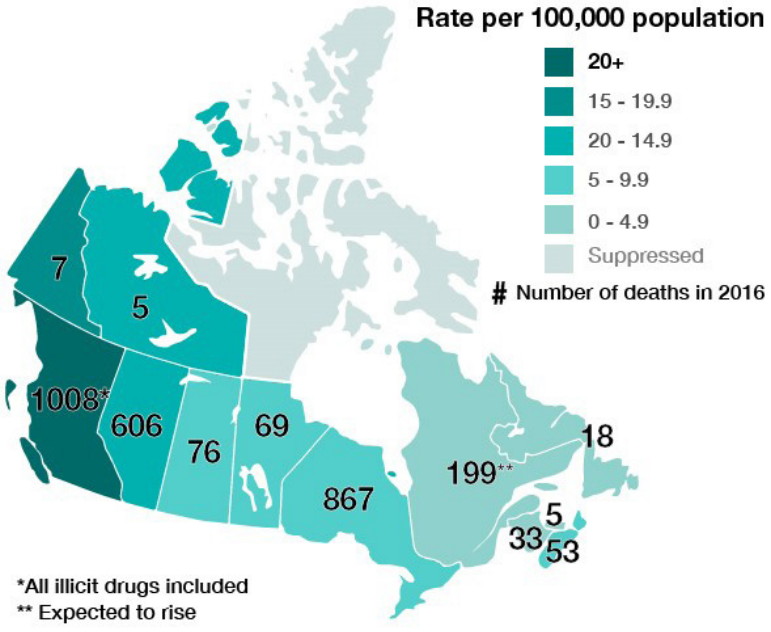
The Opioid Crisis & Mental Health

Canada is confronting an unprecedented public health crisis. In 2016-2017, an average of 16 Canadians a day were hospitalized for opioid poisonings, and in 2016 alone, over 2,861 died from opioid poisoning – the equivalent of eight deaths per day.[1] British Columbia, the province with the highest number of suspected opioid poisonings in the country, counted 1,422 deaths in 2017 alone – a 43% increase from 2016.[2] The high rates of hospitalization and mortality have most recently been attributed to fentanyl and fentanyl analogues, which are powerful synthetic opioid analgesics that have become increasingly available illegally in Canada and are finding their way into other substances sold to unsuspecting consumers. However, while the contamination of illegal substances is a significant part of the crisis, it is only one layer of a very complex problem.

Figure 01

Public Health Agency of Canada, National Report: Apparent Opioid-related Deaths in Canada (Released March 2018), Government of Canada.

Opioid Deaths Rate in 2016



Canada is currently the second largest consumer per capita of prescription opioids. While opioids have been shown to be effective for the treatment of acute pain, opioid use in the treatment of chronic pain can foster tolerance and dependence, increase the likelihood of nonmedical use, and can lead to addiction.[3] When combined with other substances, such as benzodiazepines,

This public health emergency is now taking the lives of more Canadians than the HIV epidemic did at its height in 1995.

opioids are also linked to adverse events.[4] Furthermore, while people develop problems with substance use for a multitude of reasons, there are strong links between substance use and disorders such as mental illness and trauma. In Canada, for instance, while most of the suspected opioid deaths are ruled as accidental, 8.5% of deaths in 2016 and 4.3% in 2017 were deemed the result of self-inflicted harm.[5]

The opioid crisis touches the lives of Canadians from all walks of life, but it disproportionately impacts low-income people, people who are unemployed, people with disabilities, and Indigenous communities contending with systemic racism, trauma, and intergenerational trauma.[6] As the B.C. Ministry of Mental Health and Addictions has recently stated, the overdose epidemic is very much dynamic and constantly shifting, as people who use opioids do so for different reasons and in diverse contexts, locations, combinations, and routes of administration.[7]

A complex problem such as the opioid crisis will require an equally dynamic solution. This public health emergency is now taking the lives of more Canadians than the HIV epidemic did at its height in 1995.[8] There is an urgent need for policy that is grounded in the best available evidence, as well as a need for intersectoral collaboration to support the health and well-being of Canadians who struggle with substance use and mental illness. As such, the Canadian Mental Health Association (CMHA) has created this paper to propose evidence-based/evidence-informed recommendations for government, policymakers and health organizations to support a bold and effective population health approach towards curbing the opioid crisis.

There is strong evidence to suggest that a public health approach to managing problematic substance use is much more effective than policies that punish and criminalize people who use substances, as failed anti-drug and "war on drugs" policies have shown. Criminalizing people who use illegal drugs stigmatizes substance use; it also fosters a climate in which they feel unsafe in accessing life-saving interventions and treatment services, and further marginalizes people living in poverty and experiencing racism, gender-based inequality, violence and other forms of oppression.[9] As B.C.'s Fraser Health Authority points out, "people with substance use disorders require support, not judgment" in order to heal.[10] As such, CMHA strongly supports a public health approach to tackling the opioid crisis that is based in harm reduction and treatment, and highlights the need to destigmatize problematic substance use by placing it within the realm of health care.

Increasingly, researchers and policymakers suggest that a public health approach to managing problematic opioid use should involve decriminalization. The European Monitoring Centre for Drugs and Drug Addiction explains that under decriminalization, personal use of illegal substances is not considered a criminal action, but penalties can be applied if someone is found with prohibited drugs in their possession. With decriminalization, producing, supplying and selling drugs remain criminal offences.[11] Decriminalization differs from legalization in that legalization

DECRIMINALIZATION VS LEGALIZATION

Following decriminalization, the possession, use, and acquisition of illegal drugs are no longer criminal offences. Anyone found with small amounts of drugs in their possession may receive an administrative sanction, such as a referral to treatment or fine. However, producing, supplying and selling drugs remain criminal offences.

Legalization removes prohibitions on drug manufacturing, sales, possession and personal use, although it may impose some regulations, as will be the case for cannabis in Canada.

CMHA calls for the decriminalization of all illegal substances for personal use, echoing the Global Commission in its assertion that decriminalization must be accompanied by significant investment in harm reduction and treatment measures.

removes prohibitions on drug manufacturing, sales, possession, or usage, although it may impose some regulations.[12]

The Global Commission on Drug Policy, an international commission comprised of twelve former heads of state or government, the former Secretary General of the UN, and other political and cultural leaders who advocate on drug policy, points out that criminalization carries devastating health consequences for people who use substances, including high rates of HIV, Hepatitis C Virus (HCV), and death, and that it violates the principle of human rights and dignity.[13]

Portugal, which has decriminalized all substances for personal use, has shown that substance use problems are more likely to be addressed when they are treated as health problems. In the years following decriminalization, Portugal witnessed improved health outcomes, including an increase in the number of people seeking treatment, a decrease in new cases of HIV and AIDS among people who use substances, and a reduction in the number of deaths associated with substance use.[14] These changes were accompanied by a growth in the number of treatment facilities, and a lower number of charges for drug-related offences.[15] Based on this evidence, CMHA calls for the decriminalization of all illegal substances for personal use, echoing the Global Commission in its assertion that decriminalization must be accompanied by significant investment in harm reduction and treatment measures. Addressing the health care needs of people who use opioids will require a sustained effort to destigmatize problematic drug use and scale up harm reduction, treatment and health promotion measures, while investing in wrap-around services that support recovery.

As the crisis continues to escalate in Canada, it is imperative that federal, provincial/territorial, and municipal governments not wait until the opioid epidemic spreads and deepens in other provinces and territories before taking action. The Government of Canada has already introduced important legislative changes that have had a significant impact in addressing the crisis. In 2016-2017, the federal government introduced changes to the *Controlled Drugs and Substances Act* to make the establishment of overdose prevention sites and supervised consumption sites easier, and introduced the *Good Samaritan Drug Overdose Act* to guarantee immunity to anyone who calls 9-1-1 in the event of an accidental poisoning. The Canadian government also delisted naloxone so that it is available without a prescription, and the provinces and territories have since introduced publicly-funded naloxone programs to make the life-saving drug available to first responders, front-line workers and community pharmacies. These harm reduction measures have proven successful in slowing the tide of opioid poisoning and in saving lives.

Because the crisis has been particularly acute in British Columbia, government actors, health providers, and researchers are ahead of the game, having piloted innovative and evidence-based/evidence-informed harm reduction and treatment programs that have demonstrated success in reducing the number of deaths in the province. For example, in B.C.'s 20

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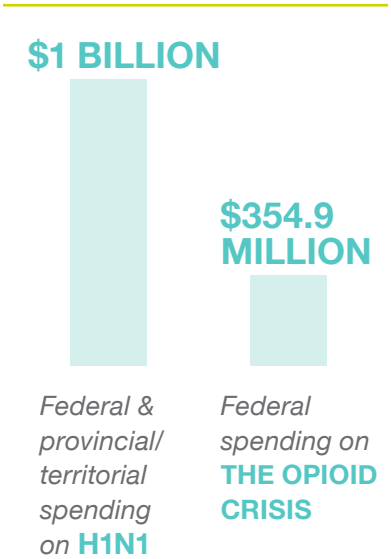
66,604 **VISITS** *were made between December 2016-March 2017 and*

481 *overdoses were* **REVERSED.**

The opioid crisis has reached its current state, in part, because there are significant barriers in access to mental health and addictions services, particularly since mental health care does not receive as much funding as physical health care.

overdose prevention sites, 66,604 visits were made between December 2016 and March 2017 and 481 overdoses were reversed.[16] Without the sites, B.C. may have had an additional 481 fatalities. We can look to B.C.'s achievements for guidance to build greater capacity elsewhere in Canada. Notably, in B.C., initiatives led by people with lived experience (PWLE) have proven particularly successful in ensuring that new initiatives are accessible, accommodating, relevant and acceptable for people who use substances. The Vancouver Area Network of Drug Users (VANDU) has changed the harm reduction approach in Vancouver and was among the first groups of its kind to reach out to the people most at risk of disease and death who were being overlooked by traditional public health services.[17] CMHA recognizes that the involvement of PWLE in planning engenders better population health outcomes, and subsequently, we call for the participation of PWLE in all levels of policy planning and program development as a guiding principle informing all of the recommendations in this report.

Addressing a crisis that is having as urgent and deadly an impact as the opioid crisis will require continued financial investment from federal and provincial/territorial governments. When the H1N1 virus broke out in 2009-2010, the Government of Canada established an Emergency Operations Centre and opened access to the Pandemic Preparedness and Response reserve fund. It is estimated that the Government of Canada and the provinces combined spent over $1 billion to address this public health crisis and provided more than 6,000 person-days to coordinate an emergency response. Although a combined estimate for the opioid crisis from the federal and provincial/territorial governments is difficult to measure, the federal government announced in 2017 that it was investing $123.5 million over five years to support the provinces and New Canadian Drugs and Substances Strategy (CDSS) national measures, and in 2016, had provided approximately 113 person-days of assistance.[18] In the 2018 budget, the federal government announced that it will invest an additional $231.4 million over five years. This funding is very much welcome and will go a long way to support new initiatives. However, given that the opioid crisis is much larger in scale and killing more than five times the number of Canadians than H1N1, more funding is urgently needed to match the scale of the current public health emergency.[19] CMHA strongly recommends that funding for harm reduction and treatment must be scaled up to address a crisis that continues to deepen every year.



While the opioid crisis requires policymakers, front-line workers, and health care providers to prioritize critical life-saving measures during this state of emergency, there are also long-term upstream measures that need to be implemented to support population health outcomes. CMHA has long been a proponent of investing in the services that support health promotion, including employment, education, income security, affordable housing, childcare and peer and family supports, among other critical social determinants of health.[20] The opioid crisis has reached its current state, in part, because there are significant barriers in access to mental health and addictions services, particularly since mental health care does not receive as much

funding as physical health care, which renders services unaffordable for many Canadians. Throughout this paper, CMHA calls for the need for greater investments in the supports and services that promote mental wellness, a role which our organization is well positioned to take given our longstanding history of connecting people seeking mental health services with these supports. Furthermore, CMHA highlights the necessity to take a needs-based and person-centered approach, and to invest in community-based treatment services that foster partnerships with primary care to support treatment within the most appropriate and least intensive treatment settings. Mental health and addictions services should be well integrated and reflect a full continuum of care to support the treatment and recovery of people who experience problematic opioid use. With 86 branches, regions and divisions in over 330 communities across Canada that collectively provide a full continuum of care, from acute inpatient, outpatient, counselling, and community-based care services and supports, CMHA is well positioned to provide leadership on community-based mental health and addictions service integration and coordination.

Finally, all policy planning and program development should be carried out in consultation with Indigenous communities, and all health and social services for Indigenous communities should be grounded in culture, be Indigenous-controlled and culturally safe, and include trauma-informed supports. Ensuring that Indigenous communities have access to culturally appropriate services at all stages – from health promotion to treatment – will assist stakeholders in the social services and mental health care sectors in supporting health outcomes for Indigenous communities and becoming allies in advancing the goals outlined by the Truth and Reconciliation Commission. This guiding principle informs all of our recommendations.

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GUIDING PRINCIPLES

Involving people with lived experience (PWLE) in policy planning and program development engenders better population health outcomes; initiatives led by PWLE have proven particularly successful in ensuring that new initiatives are accessible, accommodating, relevant and acceptable for people who use substances. The participation of PWLE should be a standard in all levels of policy planning and program development.

Policy planning and program development should be carried out in consultation with Indigenous communities, and health and social services for Indigenous communities should be grounded in culture, be Indigenous-controlled and culturally safe, and include trauma-informed supports. Ensuring that Indigenous communities have access to culturally appropriate and safe services at all stages – from health promotion to treatment – will assist stakeholders in the social services and mental health care sectors in supporting health outcomes for Indigenous communities and becoming allies in advancing the goals outlined by the Truth and Reconciliation Commission.

Methodology

The recommendations in this paper represent a collection of the strongest recommendations developed by Canadian public health organizations, governments, researchers and research institutes, including Health Canada, UBC Centre for Disease Control, BC Centre for Disease Control (BCCDC), BC Centre on Substance Use (BCCSU), Toronto Public Health (TPH), Canadian Drug Policy Coalition (CDPC), First Nations Health Authority (FNHA) and the Coalition for Safe and Effective Pain Management (CSEPM). In addition to reviewing clinical research, we conducted jurisdictional scans to examine drug policies and practices in other provinces/territories and countries. This research was also driven by CMHA's Public Policy Working Group, which is comprised of policy experts representing CMHA provincial branches, regions and divisions from across Canada, and in consultation with our National Council of Persons with Lived Experience, National Provincial Executive Team and National Board of Directors.

The recommendations in this paper are based on the four pillars' approach to problematic drug use that has been successfully implemented in Europe as early as the 1990s, which includes: Prevention, Treatment, Harm Reduction, and Enforcement. However, in recognition of the need to counter stigma and to intensify harm reduction measures in the treatment of problematic opioid use and overdose, CMHA National developed a modernized four pillars approach to problematic drug use that adds "Promotion" to "Prevention" as an essential pillar, and that renames the "Enforcement" pillar to "Collaboration and Support," to reflect the growing need to divert resources away from criminal justice to treatment, and to train law enforcement and other allies in how to best support public health measures. As such, the four pillars as updated by CMHA are described below.

1. **Promotion and Prevention:** Systemic changes to address the social inequalities that significantly impact access to mental health and addictions services and that lead to problematic opioid use, including the social determinants of health, and strategies and interventions that help prevent harmful use of illegal and prescription drugs.

2. **Treatment:** Interventions and support programs that encourage people who use substances to make healthy decisions about their lives.

3. **Harm reduction:** Strategies that aim to reduce harm for people who use substances, focusing on the harm caused by problematic substance use, with the goal of creating healthier lives for people who use drugs and a healthier community for everyone.

4. **Collaboration and Support:** Strategies to build connections and alliances among law enforcement, the justice system, and mental health professionals to ensure that persons experiencing problematic opioid use are being diverted into mental health and addictions programs instead of the criminal justice system.

SECTION I:

Promotion And Prevention

1.1 Strengthen the social determinants of health and invest in mental health services to ensure mental health for all

- Increase funding for community mental health by implementing universal health care coverage for all chronic pain management programs and mental health and addictions services, including psychotherapy, addictions counseling and other forms of treatment.
- Strengthen the social determinants of health such as housing, affordable childcare, income security, employment, education and health care, and expand and strengthen programs that support positive parenting and family relationships.
- Adopt strategies to address and prevent violence in the community and in vulnerable populations, and implement effective anti-bullying and anti-discrimination policies, programs and support services in schools and the workplace.[21]
- Advocate for and honour the recommendations of the Truth and Reconciliation Commission, support communities in moving towards greater Indigenous control of health programs and services and develop/fund practical tools and programming to support wellness for Indigenous community members and families grounded in cultural approaches.[22]
- Increase young people's access to mental health services, including access to early screening and support for mental health in schools.[23]

Context and rationale

Although many health professionals are pointing to the overprescription of opioids for physical pain as the source of the current opioid crisis, an important underlying driver that is often overlooked is the suffering caused by social inequality. It is well known that people's experiences of health are shaped by systemic inequalities and advantages linked to race, class,

Pain, they suggest, is not only physical, but is a "condition that includes economic and social disadvantage."

indigeneity, gender, sexuality, education, age, ability, citizenship status, housing and geography, among other factors.[24] For people who experience stressors related to everyday survival, who are faced with violence or who present with untreated mental illness, opioids may be used to cope with or numb psychological pain, trauma and suffering. Dasgupta and colleagues argue that the high level of opioid use in Canada and the US is rooted in suffering caused by a variety of social and economic factors that produce poor health outcomes. Pain, they suggest, is not only physical, but is a "condition that includes economic and social disadvantage."[25]

Dr. Nora Volkow, Director of the US-based National Institute on Drug Abuse, explains that "the brain adapts and responds to the environments and conditions in which a person lives. When we speak of addiction as a chronic disorder of the brain, it thus includes an understanding that some individuals are more susceptible to drug use and addiction than others, not only because of genetic factors but also because of stress and a host of other environmental and social factors in their lives that have made them more vulnerable."[26] The environment, in other words, plays an important role in shaping mental health and how individuals are able to cope with stressful situations. Stressful environmental conditions, and especially early trauma, can increase the risk of substance use. Opioids – whether prescribed by a physician or accessed through the illegal market – are widely used by people who live in stressful conditions and in chronic pain, because they are powerful analgesics, or pain relievers. Opioids operate by binding to opioid receptors in the brain, spinal cord and other tissues of the human body and triggering the flow of endorphins – the body's "natural" opioids. When they attach to opioid receptors, they alter the perception of pain by stimulating dopamine release, which, in high doses, can also engender a sense of euphoria. Over time, the analgesic effect of opioids becomes diminished (i.e. tolerance is developed), which requires higher doses to achieve pain relief, and can result in dependence or addiction.[27] Persistent environmental stress can also be the reason for continued drug use. Dr. Gabor Maté, a physician in Vancouver's Downtown Eastside, explains that stress "increases opiate craving and use, enhances the reward efficacy of drugs and provokes relapse to drug-seeking and drug-taking."[28]

Poverty is a significant environmental factor that contributes to stress, and is linked to problematic substance use. As one of the most important determinants of health, income impacts educational success, access to health care, nutrition, employment and secure housing. Poverty also impacts mental well-being and can threaten physical and mental health; studies of low-income people in different parts of Canada, for instance, have linked poverty to experiences of material and social deprivation, stress and stigma.[29] In Canada, people in low-income communities are 3.4 times more likely to be hospitalized for substance-related disorders than people in high-income communities, and hospitalization rates for mental health problems, including anxiety disorders and affective disorders, are higher overall.[30]

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Adults who have experienced childhood trauma are more likely to report chronic pain symptoms and to receive multiple prescription medications, which enhances the probability of taking opioids for pain relief and developing an addiction.

Childhood trauma is also strongly linked to problematic substance use. Recent studies exploring the connection between adverse life experiences during childhood and opioid use found that adults who reported five or more types of abuse were three times more likely to use prescription pain medication and five times more likely to consume substances through injection.[31] High rates of substance use have been documented among lesbian, gay and bisexual youth, which, while not well studied, are thought to be linked to social stigma and homophobic discrimination and violence, which produce poor mental health outcomes.[32] In addition, childhood abuse and neglect are also connected to chronic pain in adulthood. It is increasingly better understood that adults who have experienced childhood trauma are more likely to report chronic pain symptoms and to receive multiple prescription medications, which enhances the probability of taking opioids for pain relief and developing an addiction.[33]

For many Indigenous people in Canada, substance use is linked to the suffering and psychological pain of systemic racism and colonialism. While more men as a whole in Canada are dying from opioid-related harms, in Indigenous communities, both women and men are experiencing similar rates of harm from opioid use. In First Nations populations across B.C. affected by opioid poisonings, 52% are men and 48% are women.[34] Despite the fact that First Nations people only make up 3.4% of B.C.'s population, they represented 10% of all overdose deaths in 2016.[35] Maté observes that, for the high number of Indigenous people touched by opioid harms, "the sources of addiction do not originate in the substances people use but in the trauma they endured."[36] This trauma is a result of colonialism, residential schooling and cultural genocide, which has resulted in communities struggling with high rates of unemployment and poverty, low levels of education, inadequate housing, a disproportionate number of children in child protective services, and limited access to health care and social services, all of which impact the health outcomes of Indigenous people.[37]

Recent reporting on opioid harms suggests that men are overrepresented in the Canadian population as a whole. In 2016, 73% of all opioid-related deaths occurred among men.[38] Although this topic is understudied, some health care professionals are suggesting that gender and income are important factors. Fraser Health found that in a survey of 90 men admitted to the hospital for opioid poisoning, most were unemployed, underemployed or had past or current work experience in the building trades.[39] According to Dr. Victoria Lee, Chief Medical Health Officer at Fraser Health, the higher number of men may be linked to the increased risk for physical injury and the seasonal nature of the work.[40] Lee also suggests that men might be reluctant to seek help for their addictions due to the stigma of substance use and because they are also less likely than women to use health services."[41]

Given the strong link between problematic substance use and the social determinants of health, CMHA underscores health promotion as one of the most important tools at our disposal for addressing the opioid crisis. Health promotion is broadly defined as the "process of enabling people

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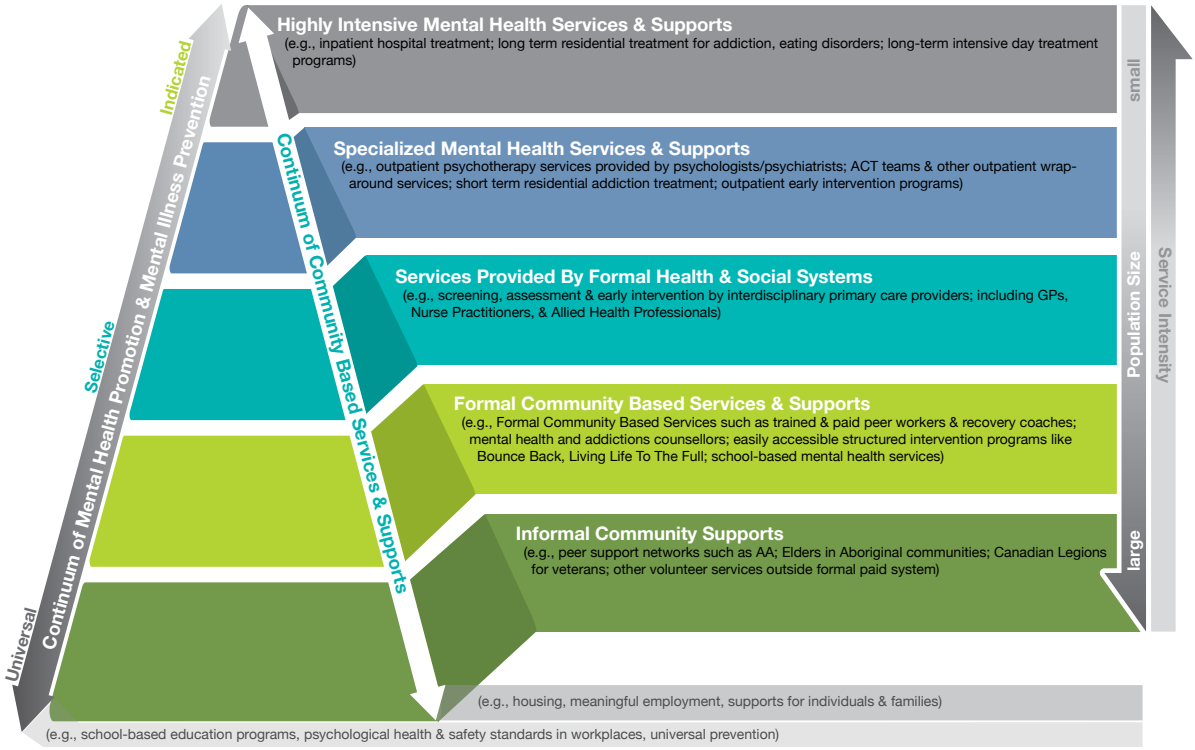
to increase control over, and to improve, their health," and includes both physical and mental health. Health promotion rests on building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and re-orienting health services.[42] At CMHA, we have adopted the Ottawa Charter for Health Promotion (1986) which recommends that action be taken in the five following areas:

- **Creating supportive environments,** by improving housing conditions, reducing the strain of unemployment, reducing stigma and supporting students with mental illness;
- **Building individual skills,** through mental health clubs for youth in schools to enhance resilience and promote social competence, and education programs for adults to increase literacy and strengthen confidence and inclusion;
- **Developing healthy public policy,** by developing healthy workplace policies and funding PWLE-controlled organizations;
- **Reorienting mental health services,** through early intervention in mental health, adopting a consumer-centered approach, enhancing individual agency and participation in community life, and strengthening the social determinants of health;
- **Strengthening community action,** by promoting supports for older adults, linking youth with physical care, promoting and enhancing partnerships between communities and schools to support youth and prevent substance use and connecting people with mental illness to the community.[43]

Community-based organizations have an important role to play in health promotion. For most Canadians, mental health and substance use problems go untreated. A study from 2001, for instance, found that only 40% of Canadians with diagnosable disorders sought help for their mental health or substance use problems, and that people with co-occurring disorders were more likely to report that their health care needs were not being met.[44] An ongoing problem in the Canadian health-care system is that efforts to improve health care have been focused on the acute care system, while community-based mental health services, which provide early intervention and help reduce the pressures on hospital, police and social services, receive a smaller share of the funding.[45] As a result, many people with complex chronic health problems are not receiving the full scope of care they need and end up "cycling through the acute care system."[46] The problem with this system is that a greater reliance on acute care to meet mental health care needs results in "emergency department overcrowding, revolving door psychiatric admissions and discharges and high and increasing demands on police and social services."[47] Greater use of acute care also reduces the amount of space available for inpatient treatment and increases wait times for services. There is a strong need to provide better funding for community-based,

publicly-funded health care and mental health services to guarantee equitable access for people who are marginalized, and to ensure that they are being supported with a full continuum of services.

Figure 02 **CMHA National Stepped Care/Matching model**



CMHA underscores the efficacy of the stepped care/matching model for mental health care provision, which is based on the principle of "least burden" and relies on matching individuals with the least intensive/least intrusive service level that is likely to meet their needs. In the stepped care/matching model, service providers consider the patient's complexity and level of need and triage them into the least intensive service that is likely to be effective. The lower tiers, Tiers I and II (figure 02), which include those areas where the supports are more community-based, more reliant on non-specialist and peer support, and less reliant on health care resources, are currently valuable but underutilized in supporting people with mental health and substance use problems. These tiers include recovery coaches, mental health and addictions counsellors, school-based mental health services, screening and early intervention, nurse practitioners and structured intervention programs like Bounce Back®. Investment in these tiers would provide the dual benefit of enhancing mental health promotion and reducing the strain on acute care services. As CMHA branches are embedded in 330 communities across Canada and offer a continuum of services, we are in a good position to provide leadership in health promotion and community-based service provision.

1.2 Build on public education programs that take a public health approach to preventing and addressing problematic substance use

- Work in partnership with provincial/territorial health organizations and any other associated groups to promote awareness of the fatal potency of fentanyl and the contamination of the illegal opioid supply with fentanyl analogues, the potential harms of prescription opioids, the risks of overdose, and the dangers of combining other drugs (alcohol, benzodiazepines, other opioids) with opioids.
- Ensure that public advertisement campaigns do not use stigmatizing language or employ ineffective scare tactics.
- Develop e-mental health technologies to educate about safer substance use.
- Develop and build on programming for youth that takes a strengths-based approach and encourages community connectedness by providing them with access to quality recreational and out-of-school programs.[48]
- Scale up peer-led prevention teams that target concerts and music festivals to provide potential opioids consumers with naloxone kits, information about the risks of opioids use, counselling, and resources for treatment.

Context and rationale

Fear has been shown to be an ineffective tactic in preventing substance use for young people. Although advertisements aimed at substance use prevention among youth have been using scare tactics since the 1960s, research suggests that this approach is largely ineffective.[49] Some studies have found that campaigns based on fear and promoting abstinence from substance use fail to motivate young people to change their behaviour, and may in fact appeal to their desire for risk-taking or may even foster an attitude of apathy, disbelief, or fatalism about the possible harms of substance use.[50] Fear tactics that emphasize the negative impact of substance use can also further isolate and marginalize youth who are using substances and prevent them from seeking help.[51] Despite the proven ineffectiveness of fear-based advertising, many community organizations and governments continue to mobilize fear in an attempt to turn the tide on the opioid crisis. In response to these campaigns, B.C.'s Chief Coroner, Lisa Lapointe, released a statement condemning such advertisements, noting that "they tend to increase the

"Fear-based advertisements tend to increase the stigma surrounding drug use and actually discourage people from seeking help – an obsolete approach that has led to the loss of countless lives."

Lisa Lapointe
Chief Coroner, B.C.

stigma surrounding drug use and actually discourage people from seeking help – an obsolete approach that has led to the loss of countless lives."[52]

CMHA recommends that public education initiatives warning about the harms of opioids should be based on the principle of harm reduction and should reduce stigma associated with substance use. While we recommend educating about the dangers of contamination of illegal substances with fentanyl, we also highlight the importance of avoiding common pitfalls of substance use advertising, such as using drug imagery and stigmatizing language. Images of injection paraphernalia and pills have been shown to stimulate cravings in people who inject and use prescription opioids, and are thus not conducive to helping people who struggle with problematic opioid use or are in recovery.[53] Furthermore, stigmatizing language such as "drug abuser" and "addict" in advertising reporting on the fentanyl crisis fosters "social disapproval and prejudice – by family, peers, and neighbours – [and] makes people more likely to use drugs alone, out of reach of care in the event of an overdose."[54] CMHA strongly believes that care, compassion, and the encouragement of help-seeking are much more compelling approaches to reducing the harms associated with substance use.

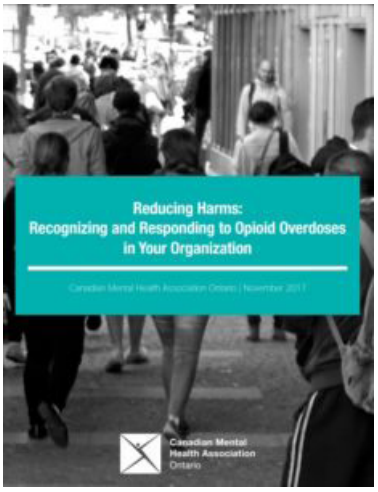
In the school setting, youth programs that emphasize harm minimization are more effective in engaging young people in conversations about substance-related harms.[55] A harm minimization approach "implicitly and/or explicitly accepts a range of substance use patterns along a continuum of risk" and, taking into account psychosocial development, aims to "provide accurate and credible information to promote responsible decision-making and behaviour regarding the use of drugs and alcohol."[56] The accepted best practices also include using strengths-based approaches that foster resilience rather than focusing on deficits, using a trauma-informed approach, engaging young people in activities that are interactive, activity-oriented and engaging and that promote strong relationships and school engagement.[57] Given that youth can be a population that is difficult to reach, and as their social worlds are embedded in social media and digital technologies, CMHA also recommends exploring and expanding e-mental health services as a possible platform for education on safer substance use.[58]

Although not well studied, peer-to-peer programming can play an important role in educating young people about safer drug use. The TRIP! Project, for instance, is a youth-led harm reduction project in Toronto that sets up booths at electronic music events where youth are likely to use drugs. Volunteers are trained in basic counselling, crisis intervention, CPR and how to handle drug-emergencies, and they also provide information and supplies for safer drug use and safer sex.[59] Projects such as this one can be valuable because they increase youth participation and voice. Youth may also be more comfortable accessing peer-led services in some cases; a survey of teens in Toronto, for instance, found that 53% preferred to seek out friends, siblings and infolines for health questions rather than talking to health workers.[60]

Care, compassion, and the encouragement of help-seeking are much more compelling approaches to reducing the harms associated with substance use.

1.3 Continue to work collaboratively with all levels of government, in consultation with public health and community stakeholders, Indigenous communities and people who use drugs, to implement a comprehensive, evidence-based/evidence-informed overdose prevention and response plan

- Dedicate a coordinator and funding to support the implementation of a federal strategy across ministries and sectors.[61]
- Promote Health Canada's "Opioid Toolkit" to teach about how to recognize and respond to overdoses and promote awareness nation-wide about *The Good Samaritan Drug Overdose Act* to eliminate the fear of criminalization that often acts as a barrier to calling emergency responders (911) during a drug overdose.
- Train family, friends, and peers on how to respond to an opioid-related emergency by including information on the prevention, detection, and appropriate response to overdose, including the recognition of symptoms and administration of naloxone.[62]
- Support a process for Indigenous communities to develop and lead discussions about overdose prevention and response strategies for Indigenous communities.[63]
- Continue to work with the provinces and other authorities to develop on-going training and programs in administering naloxone[64] (e.g., supplying workplaces with Naloxone kits and providing staff training in how to respond to opioid overdoses, as outlined in CMHA Ontario's toolkit Reducing Harms: Recognizing and Responding to Opioid Overdoses in Your Organization).[65]



Context and rationale

As the number of accidental poisonings and fatalities from both prescription and illegally-obtained opioids has been increasing, many community organizations have responded by forming committees and releasing overdose prevention plans/drug strategies focused on opioid harms in their communities. In their reports, they have made calls for municipal, provincial/territorial and federal governments to take action; a number of these strategies called for: increased access to naloxone; first responders to be equipped with naloxone access and training; Good Samaritan legislation; the appointment of provincial/territorial overdose coordinators; and the timely collection of data on

The reintroduction of harm reduction was a monumental step in re-aligning the Canadian drug policy with a focus on public health.

overdose events.[66] Several identified "policy barriers that hinder the scale-up of opioid overdose prevention and treatment initiatives in Canada" and called for comprehensive federal and provincial overdose plans.[67]

In response to these calls to action and the worsening situation, the federal government in 2016 began introducing significant measures to address the opioid crisis. In December 2016, the Government of Canada replaced the National Anti-Drug Strategy introduced by the previous government with the Canadian Drugs and Substances Strategy. In 2007, the previous federal government had eliminated harm reduction from the national drug strategy and allocated the lion's share of federal funding to enforcement – with 70% dedicated to law enforcement – while prevention and treatment received only 4% and 17% of the funding, respectively.[68] The reintroduction of harm reduction was a monumental step in re-aligning the Canadian drug policy with a focus on public health.

In 2016, the former Minister of Health Jane Philpott and former Ontario Minister of Health and Long-Term Care Eric Hoskins also convened the Opioid Conference and Opioid Summit, which brought together stakeholders from across Canada and resulted in the Joint Statement of Action to Address the Opioid Crisis (2016). The Joint Statement identified "specific actions to address this crisis and publicly commit to taking these actions."[69] Since it introduced the Statement, the federal government has taken action on several important items: it passed the *Good Samaritan Drug Overdose Act,* which provides legal protection for people who seek emergency help during an accidental poisoning; amended the *Controlled Drugs and Substances Act* to make it easier for municipalities to establish supervised consumption and overdose prevention sites; increased the accessibility to naloxone by making it available without a prescription; re-opened the Special Access Programme to allow physicians to access diacetylmorphine to treat patients who have not benefitted from other forms of opioid agonist treatments; funded innovative harm reduction pilots through the Substance Use and Addictions Program; and established the Special Advisory Committee on the Epidemic of Opioid Overdoses to improve the surveillance and data collection on opioid-related deaths.[70] The federal government has also re-distributed federal funding so that prevention, harm reduction and treatment receive a larger share of the support and announced, in 2017, that it will legalize and regulate cannabis by July 2018 to align Canadian cannabis policy with public health interests.

These efforts reflect the Government of Canada's willingness to take a leadership role and work collaboratively with a wide range of stakeholders across sectors to address the crisis. Even given these steps, the crisis continues to escalate, which highlights the importance of federal, provincial/territorial and municipal governments continuing to work together to scale up their efforts in preventing further harms. Notably, several community organizations highlight the need to build on the success of publicly-funded naloxone programs and to continue to enhance access to and training for naloxone for family members, friends, teachers and workplaces.[71] Some organizations do not have an overdose prevention protocol or face barriers

THE GOOD SAMARITAN DRUG OVERDOSE ACT

provides some legal protection for people who experience or witness an overdose and call 9-1-1 for help.

to establishing one; however, in many municipalities, efforts are underway to expand naloxone training and implement an overdose protocol. Toronto Public Health, for instance, has been working with branches of the Toronto Public Library to provide training in the administration of naloxone.[72] CMHA Ontario has also developed a toolkit that provides community service providers with up-to-date information for developing an opioid overdose protocol, which includes information on monitoring and reporting overdoses as well as debriefing and distress prevention in the workplace.[73]

The Government of Canada also introduced public service announcements in 2017 on the *Good Samaritan Drug Overdose Act,* and should continue to raise public awareness about the Act to reduce the fear of arrest that often prevents many people who use substances from calling first responders in the event of an opioid poisoning.[74]

Community-based drug strategies continue to stress the urgency of the opioid situation. As recently as May 2017, Toronto Public Health identified a need for the federal government to develop an overdose strategy with a dedicated coordinator and funding to facilitate collaboration among federal and provincial/territorial governments.[75] The Municipal Drug Strategy Coordinators Network of Ontario and the Waterloo Region Crime Prevention Council, which have also called for a federal strategy, have suggested that it should also include "defined overdose reduction targets," timelines and allocated funding for reducing opioid harms. In addition, they reaffirm the need for provinces to implement and build on poverty reduction strategies and improve access to supportive housing and treatment services.[76]

1.4 Create a national system for the collection, analysis and dissemination of comprehensive data and surveillance on drugs that mandates all provinces/territories to track and log data on the number of opioid-related overdoses and fatalities

- Establish a permanent organization for training and accrediting coroners and medical examiners and institute a national reporting system to make data across Canada on opioids and opioid-related harms consistent and comparable.
- Improve data sharing among law enforcement, public health, researchers, coroners services, and drug analysis and toxicology labs to ensure that data is delivered on a real-time basis to improve response plans and early warning to reduce harms.[77]

CMHA strongly recommends that the federal government create a permanent organization to provide systematic training and reporting for coroners and medical examiner offices to make data across Canada on opioids and opioid-related harms consistent and comparable.

Context and rationale

There is a lack of quality data on opioid use and opioid-related harms in Canada. Nationally, little is known about the extent of hospitalizations and fatal poisonings, the types and potencies of illegal drugs in circulation, prescription opioid dispensing or treatment outcomes for people who access services for opioid use disorders. Although some provinces like B.C. and Alberta produce frequent reports on opioid harms, other provinces are behind with their data.[78] Furthermore, the wait time for toxicology and drug tests for suspected opioid deaths in some provinces can be as long as two months.[79] The lack of consistency and of timely reporting means that the number of opioid-related harms and deaths from opioid poisoning, and particularly from fentanyl and fentanyl analogues, is almost certainly underreported in Canada.

This inconsistency across Canada stems from the varying reporting methods and frequencies across provinces/territories and municipalities.[80] Coroner and medical examiner offices, which are the bodies responsible for examining and reporting on suspicious deaths for each province/territory, all have individual reporting systems. As a result, reporting practices among them vary, which renders their data difficult to compare. Since 2014, Dr. Matthew Bowes, Chief Medical Examiner in Nova Scotia, has been calling for the systematization of chief coroner reporting and training, noting that there is "no accreditation system for coroner or medical examiner offices, no national standards for the investigation or classification of death, no nationally recognized training program or credentialing system for coroners and medical examiners and no agreement on common outcome measures against which to evaluate performance."[81] As Bowes suggests, quality reporting is important because data can have "widespread public health implications": "assigning deaths as 'undetermined' in cases of drug overdose…because an investigation or autopsy was not done, precludes efforts to prevent future deaths."[82] Without accurate and quality reporting, it is difficult to engage in prevention efforts to stem the opioid crisis.

To improve data surveillance, the Government of Canada formed a Special Advisory Committee on the Epidemic of Opioid Overdoses co-chaired by the Chief Public Health Officer of Canada, Dr. Theresa Tam, and the Chief Medical Officer in Nova Scotia, Dr. Robert Strang, who created an Opioids Overdose Surveillance Task Group. The Task Group has worked collaboratively to establish a common definition for "opioid-related deaths" that has been adopted by all jurisdictions, and also introduced quarterly reporting for overdose deaths, both of which are important steps in improving national surveillance data.[83] With a view to improving and systematizing future reporting, CMHA strongly recommends that the federal government create a permanent organization to provide systematic training and reporting for coroners and medical examiner offices to make data across Canada on opioids and opioid-related harms consistent and comparable.

For a crisis that is as acute as the fentanyl emergency in Canada, a systematized reporting system that releases data in real time is essential.

In establishing a system for harmonizing the efforts of coroners and medical examiner offices, the provinces and territories can look to B.C.'s reporting system. In 2017, the B.C. Coroners Service developed an Unintentional Drug Overdose Protocol, which requires coroners to complete an eleven-page report for every person who has died from a suspected opioid poisoning. In addition to collecting the usual information that is required for a coroners' report, such as the post-mortem and toxicology exam, the protocol also collects information about the residence type of the deceased, their occupation, previous health diagnoses, whether they presented with a history of mental health problems or trauma, past patterns of substance use and utilization of treatment services.[84] CMHA applauds this comprehensive approach for data collection, which will better capture data on the populations most affected by fatal poisonings and will improve the gaps in knowledge on substance use and its links to addictions, mental health and service use.

The Government of Canada is currently addressing the lack of quality and comprehensive data by developing a national surveillance system – or a "national drugs observatory" – that will be co-managed by the federal and provincial/territorial governments. The initiative, which is scheduled to launch in Spring 2018, will standardize data collection and reporting on a wide range of substances. The project is now in the implementation planning phase and Health Canada is currently assessing which metrics the drug observatory will capture. CMHA applauds this initiative and hopes that the drug observatory will capture a wide range of data relating to substance use, addiction, mental health and treatment pathways, much like the system established by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The EMCDDA collects standardized data and research from the EU and its Member States on the prevalence of drug use, problematic drug use, drug seizures and harms associated with substance use. It also has a treatment demand indicator that tracks information on the people who seek services at treatment facilities, which helps identify patterns in service use and better assists EU Member States in health care policy and planning.[85]

Finally, for a crisis that is as acute as the fentanyl emergency in Canada, a systematized reporting system that releases data in real time is essential. Michael Parkinson, a drug strategy specialist with the Waterloo Region Crime Prevention Council, suggests that identifying "hot spots" for fentanyl overdoses is crucial. Real-time reporting of poisonings would help paramedics and front-line workers better respond to emergencies and issue warnings when a particular drug is contaminated with fentanyl.[86]

SECTION II:

Treatment

2.1 Research, fund and improve access to treatment for Opioid Use Disorder, including evidence-based/evidence-informed alternative treatments

- Enhance the capacity of organizations that support and treat people who use opioids with funding and resources to reduce wait times and unaffordable user or clinic fees.[87]
- Improve the integration of treatment services with primary and mental health care, including harm reduction services and trauma-informed care.[88]
- Establish and invest in supportive housing to end chronic homelessness for people who use drugs to improve their health outcomes and increase their access to treatment.
- In provinces where therapies such as Opioid Agonist Therapy (i.e. buprenorphine/naloxone and methadone) are lacking, improve access to treatment.
- Expand the models of treatment to ensure that individuals can access appropriate services when they need them and that evidence-based treatments such as diacetylmorphine-assisted and hydromorphone therapy are part of the continuum of treatment for those who have not benefitted from other therapies.
- Ensure that no one is refused entry into a provincially-funded substance use treatment program because they have an opioid substitution treatment or any other prescription.[89]
- Recognize the value of Indigenous healing practices and use them in the treatment of Indigenous people in collaboration with Indigenous healers and Elders where requested, as recommended by the Truth and Reconciliation Commission.[90]
- Expand the availability of appropriate withdrawal management and treatment services, particularly for youth and for expectant and new mothers. Ensure that wrap-around services are available to support treatment and recovery.[91]

There is a need to develop a stepped and integrated approach to care in which care professionals work with individuals to develop personalized treatment plans that are low barrier and predict patient need.

- Explore psychotherapy, physiotherapy, meditation and other alternative treatments as a substitute for, or as treatment options to be used in conjunction with opioid agonist therapy.
- Explore promising new research on cannabis as an alternative form of treatment to substitute opioids for pain management, to manage withdrawal symptoms, and/or treat substance use problems.

Context and rationale

Although opioid use disorder can often be cyclical in nature, with the right supports, recovery is possible. Supportive services and treatments that facilitate recovery might include addictions counselling, cognitive behavioural therapy, consultations with addiction medicine physicians and social workers, life-skills counselling, housing referrals, trauma therapy, medication-supported detoxification, opioid maintenance treatment, peer-support, specialized services for Indigenous people, women and youth, etc. Community-based services are critically important in treatment and recovery. As Fischer and colleagues suggest, in addressing opioid use disorders, there is a need to develop a stepped and integrated approach to care in which care professionals work with individuals to develop personalized treatment plans that are low barrier and predict patient need.[92] An integrated approach to care should also involve partnerships among community-based services and primary care (e.g. community health centres, family health teams).[93]

Access to services

The high cost of services and long wait times are often significant barriers to accessing addictions treatment. For people seeking methadone treatment, for instance, wait lists among the provinces can range from two weeks to 12 months and, in rural, remote and Indigenous communities, services may be nonexistent or require substantial travel.[94] While publicly-funded residential treatment services are often fully covered by the government, they typically have longer wait lists than private treatment centres, which are paid out of pocket or through private insurance and can cost upwards of $12,000 a month.[95] A survey conducted in 2013 of 203 publicly-funded provincial substance use treatment agencies in Ontario found that 65% maintained a wait list, and that 56% of the agencies with community withdrawal management programs were “overburdened with their wait list.”[96] These long wait times are problematic, as research shows that individuals placed on a wait list during initial contact for intake and enrolment in treatment services are less likely to enroll.[97] Recognizing that treatment on demand is critical for recovery, CMHA strongly recommends significantly increasing funding for publicly-funded treatment services to eliminate prohibitive costs and to ensure that there is adequate space within treatment facilities to meet the demand.

Access can be particularly difficult for vulnerable populations. For Indigenous communities on reserve, community-based services are often only

available off-reserve, which means that the services may not be culturally appropriate or safe. Additionally, the support that would otherwise be provided by the community and family network may not be available off-reserve.[98] Furthermore, the lack of integration among federal, provincial, and territorial services produces gaps in the continuum of care of mental health and addictions services for many Indigenous people.[99] Best practices recommend that treatment for Indigenous people should be trauma-informed and strengths-based, and that it should foster the resilience of individuals, families, and communities.[100] Treatment options should also be specific to community needs, include options for land-based treatment, and involve aftercare supports such as counselling, access to cultural practitioners and community-based workers, education, training, employment and skills development, housing, childcare and supports for parents.[101]

Youth, both Indigenous and non-Indigenous, also face barriers in access to treatment. A study in Ontario found that youth often face age exclusions from adult treatment centres and are required to access services outside of their communities, which removes them from their support systems. In addition, youth are particularly vulnerable because they depend on family for the necessities of life and are vulnerable to abuse.[102] Mae Katt, who is Ojibwa and a nurse practitioner, developed a unique program in a Thunder Bay high school that provides buprenorphine/naloxone along with cultural, educational and spiritual supports for youth who experience problematic opioid use. The program meets youth where they are and provides them with the support of Elders and counselling to manage stress.[103] Community-based, Indigenous-led initiatives such as this one should be supported and scaled up in communities where there is a demand for youth treatment services. For youth, better access to treatment services also requires a developmentally-informed continuum of care that is accessible, presents flexible treatment options, and supports the social determinants of heath.[104]

Furthermore, mothers also require special consideration when it comes to treatment. A rising number of children are born with neonatal abstinence syndrome, a condition in which newborns go into withdrawal shortly after birth following pre-natal exposure to opioids.[105] With the sharp rise in acute hospitalizations for neonatal abstinence syndrome, there is a need for better and more integrated services for new and expectant mothers.[106] Fostering an environment that is free of judgment will help new and expectant mothers access treatment. In addition, recent literature suggests that rooming-in, which allows the mother and infant to remain together rather than separating the child into the Intensive Care Unit (ICU), can improve the health outcomes for mother and child.[107] Regardless of the pathway of care, once they leave the hospital, mothers and newborns require wrap-around services, including primary health care, supportive family services and carry-home treatments where appropriate.[108]

Community-based, Indigenous-led initiatives *should be supported and scaled up in communities where there is a demand for youth treatment services.*

The long wait times and gaps in access to treatment services in our current system of care are the consequences of a fragmented and poorly

Given that housing is a critical social determinant of health, CMHA strongly recommends investment in supportive housing for people who face mental health and substance use challenges.

coordinated system of services and supports.[109] Too often, people seeking treatment for substance use problems do not receive the treatment they need because services are not always equipped to manage acute and concurrent health conditions or they may present other barriers such as eligibility requirements.[110] In response to these problems, and in recognition that there is a greater chance of success in treating mental health and substance use problems together, the Royal Ottawa has developed a Regional Opioid Intervention Service (ROIS) that delivers concurrent disorders care for opioid addiction and mental health problems. The Service is managed by a multidisciplinary team of community agencies, hospital programs and family physicians, which collaborate to offer a full spectrum of care.[111] Using the hub and spoke model, ROIS aims to "foster the linkages and integration of addiction, mental health, and primary care services, and bring care closer to where patients live," all the while ensuring that the care provided is appropriate and tailored to individual needs.[112]

Supportive housing is critical for facilitating access to treatment and improving health outcomes for people who use substances. Experience with problematic substance use should not be a barrier to accessing housing, given the proven benefits of housing for harm reduction and recovery. The Housing First model, for instance, a program that provides persons experiencing homelessness and mental health and addictions challenges with direct access to housing, promotes recovery by ending homelessness and collaborating with the individual to create a care plan that may include a range of services, such as acute medical care, family services, addictions counselling and vocational training.[113] Housing First has proven effective in facilitating "improvements in health, substance use, and community integration" for people who experience homelessness.[114] Given that housing is a critical social determinant of health, CMHA strongly recommends investment in supportive housing for people who face mental health and substance use challenges.

» *Treatment of opioid use disorder*

Currently, there are inconsistencies in how opioid use disorders are treated in Canada. As the Canadian Centre on Substance Use and Addiction (CCSA) notes, services for substance use treatment in Canada fall under different types of jurisdictions, which "vary widely in their structure, organization, accountability, accessibility, ideology and sources of funding," and produce "fragmentation and inconsistency" rather than an integrated system of services.[115] Until recently in many Canadian provinces, methadone has been the first line of treatment for opioid use disorder, but since 2007, when buprenorphine/naloxone was approved in Canada, some provincial guidelines have been updated to favour buprenorphine/naloxone as the first line of treatment. This change is a welcome step in ensuring that treatment for opioid use disorder is based in sound evidence, given that the lack of national guidelines and absence of evidence-informed practice has led to inappropriate prescribing in many provinces, as Fischer and colleagues illustrate through Ontario's example with methadone.[116] While the national

CMHA is in strong agreement with BCCSU that a national guideline must present "the full range of therapeutic options for the optimal treatment of adults and youth with varying presentations of opioid use disorder."

guideline for prescribing opioids for chronic non-cancer pain has been around since 2010, a national guideline for the treatment of opioid use disorders was only introduced in March 2018. The *National Guideline for Best Practices in the Clinical Management of Opioid Use Disorders,* produced by the Canadian Research Initiative in Substance Misuse (CRISM), is based on the 2017 British Columbia Centre on Substance Use (BCCSU) and B.C.'s Ministry of Health provincial guideline and, consistent with research and best practice, recommends buprenorphine/naloxone as the first line of treatment for opioid use disorder followed by methadone and slow-release oral morphine.[117]

CMHA is in strong agreement with BCCSU that a national guideline must present "the full range of therapeutic options for the optimal treatment of adults and youth with varying presentations of opioid use disorder."[118] A full range of therapeutic options should include non-pharmacological interventions such as psychotherapy and psychosocial supports, community-based supports, and referrals to health and social services, in addition to pharmacological interventions such as medications-supported detoxification/tapering and opioid agonist therapy, among others. CMHA strongly supports CRISM's national guideline recommending that prescribing physicians take a stepped and integrated approach that bases treatment plans on patient need, established through a comprehensive assessment of the patient's circumstances.[119] However, a serious limitation in the new guideline is that it is based only on "treatment approaches for opioid use disorder currently available in Canada" and thus excludes "pharmacotherapies not yet widely available in Canada, including long-acting and extended-release opioid antagonists, as well as injectable opioid agonist treatment (i.e. diacetylmorphine and hydromorphone)."[120] BCCSU has also excluded these therapies from its provincial guideline, although the Centre developed an ancillary document for injectable opioid agonist treatment that provides clinical guidance for injectable hydromorphone, specifying that injectable Opioid Agonist Therapy (iOAT) should be considered an integral part of the continuum of care for addressing opioid use disorder.[121]

The exclusion of evidence-based alternative therapies such as iOAT from the national guideline is a concern to CMHA given that it risks missing a population that uses non-medical opioids and that is highly vulnerable to fatal fentanyl poisoning. For a small number of people with opioid use disorder who have exhausted other forms of agonist therapies such as methadone and buprenorphine, injectable diacetylmorphine and hydromorphone have shown success in reducing non-medical opioid use, criminal activity, incarceration, mortality, disease associated with injection, and treatment dropout, as evidenced in pilot studies in B.C. (SALOME and NAOMI) and in Switzerland, where prescription diacetylmorphine treatment is legal.[122] Given the dangers of fentanyl and fentanyl analogues in the illegal drug supply, BCCSU suggests in its clinical guidance document that there is a "profound need to improve the overall OUD [opioid use disorder] system of care, including expanding treatment options for those patients with opioid use disorder who have not benefited from other treatments."[123] CMHA thus suggests that injectable

CMHA strongly supports alternative treatments that help people who use substances address trauma and manage concurrent disorders such as depression and anxiety.

hydromorphone and diacetylmorphine be included within the continuum of care in the guideline for opioid use disorder. CMHA also urges the federal government to increase the availability of these treatment options so that they are accessible to the people for whom these treatments are deemed appropriate and who are at the highest risk of opioid-related harms from the contaminated drug supply.

CMHA strongly supports alternative treatments that help people who use substances problematically address trauma and manage concurrent disorders such as depression and anxiety. Currently, the evidence base for the effectiveness of behavioural treatments alone and in combination with opioid agonist treatments is limited and has yielded mixed results; however, there is agreement that this issue remains underexplored and that psychosocial supports should be offered in conjunction with treatment plans for people with opioid use disorders.[124] Although BCCSU acknowledges this limited evidence, the Centre nevertheless recommends that psychosocial treatment supports be the "standard of care for management of any complex or chronic medical condition," and that "all clinicians should provide medical management, including general support and unstructured counselling, to patients with opioid use disorder."[125]

Some recent studies have also explored therapeutic interventions beyond psychotherapy, such as yogic breathing and mindfulness, and have reported improvements in the quality of life and decreases in pain, stress and desire for opioids for people with opioid use disorders.[126] Furthermore, cannabis is beginning to be studied as a possible treatment pathway for decreasing opioid use. A recent research study exploring cannabis use among people who access a dispensary in Vancouver found that cannabis use reduced opioid use and helped manage symptoms of withdrawal.[127] These alternative forms of treatment deserve further research to explore their possible benefits for recovery. A crisis of this magnitude calls for new and innovative approaches, and a renewed commitment to exploring alternative treatments.

2.2 Develop a National Pain and Addictions Strategy that includes investment in research, education and clinical care targeted toward finding safer pain management approaches

A crisis of this magnitude *calls for new and innovative approaches, and a renewed commitment to exploring alternative treatments.*

- Enhance access to non-opioid and non-pharmacological treatment options for pain by publicly funding alternative therapies.
- Empower patients and prescribers to make safe choices in pain management by promoting more collaborative and better-shared decision-making between patient and clinician.[128]

- Ensure that opioids are not prescribed with other depressants and that patients are aware of the risks of taking opioids in combination with medications such as benzodiazepines and substances such as alcohol.[129]

- Improve pain management and addiction education for all health professions, from undergraduate through postgraduate and continuing professional development programs.[130]

- Evaluate the unintended consequences of *The 2017 Canadian Guideline for Opioids for Chronic Non-cancer Pain* (National Pain Centre), which has reduced the maximal daily dose from 200mg to < 90 mg morphine equivalents daily.[131]

- Develop prescription monitoring programs (PMPs) that allow for consistent and systematic comparisons across provinces but ensure that they do not limit access to pain treatment or to treatment for people living with problematic substance use or with opioid dependencies.[132]

- Consult with people who use drugs and other experts before changes are made to the availability of pharmaceutical drugs, such as delisting opioids from provincial drug plans, to ensure new regulations do not force people into illegal markets.[133]

Context and rationale

In Canada, opioids are commonly prescribed to treat acute and chronic pain. They are used to treat pain linked to surgery, chronic conditions such as musculoskeletal and lower back pain, cancer pain, and in palliative care. As noted in the previous section, they are also prescribed to treat opioid use disorder. While opioids have been shown to be effective in managing certain kinds of pain such as cancer and post-surgical pain, their effectiveness has been called into question with respect to managing chronic conditions.[134] In the 1990s, opioids were falsely promoted as safe and effective medications for treating chronic pain, a claim that is now challenged by research that suggests that the long-term efficacy of opioids in the treatment of chronic pain is not only unclear, but that long-term use is in fact also linked to a greater number of harms.[135]

In response to the high rate of opioid-related harms in Canada linked to overprescribing, different strategies have been implemented to monitor and restrict prescribing. Recently, the National Pain Centre released *The 2017 Canadian Guideline* that sets new limits on the maximal daily dose of opioids for the treatment of non-cancer pain. The new guideline, which replaces the *2010 Guideline,* has lowered the daily limit from a "watchful dose" of 200mg of morphine-equivalents daily (MED) to <90mg MED, with

Researchers recommend that provincial governments develop prescription monitoring programs that allow for consistent and systematic comparisons across provinces, but that they do not limit access to pain treatment or to treatment for people living with problematic substance use or with opioid dependencies, a recommendation that CMHA strongly supports.

the stipulation that a dose of <50mg is optimal. *The 2017 Canadian Guideline* also recommends optimizing alternative forms of treatment and encourages physicians to consider tapering patients already using opioids for non-cancer pain.[136] Furthermore, several provinces have instituted prescription monitoring programs (PMPs) to reduce the potential harms associated with prescription drugs, monitor dispensing information, reduce the diversion of prescription drugs and address the problem of "double-doctoring" (whereby patients visit multiple physicians to obtain prescriptions). Some provincial Colleges of Physicians and Surgeons have also begun investigating physicians who prescribe opioids at rates higher than the average. These investigations can result in disciplinary action.[137]

Fischer and colleagues argue that it is important to implement monitoring practices to reduce opioid-related harms and to ensure that there is accurate and consistent data on prescription opioid use, including problematic use, in Canada. However, they also caution that there are potential undesired consequences of these initiatives, which can include: separating patients into the categories of "legitimate patients with pain" and "abusers," a divide which is stigmatizing and likely does not exist; and a reluctance among physicians to prescribe opioids, with possible reliance on less effective and more dangerous substitutes to treat chronic pain. These researchers thus recommend that provincial governments develop prescription monitoring programs that allow for consistent and systematic comparisons across provinces, but that they do not limit access to pain treatment or to treatment for people living with problematic substance use or with opioid dependencies, a recommendation that CMHA strongly supports.[138]

CMHA believes that prescription reduction measures will do little to stem the opioid crisis unless they are accompanied by an investment in safe and effective alternatives for the management of pain. Since 2011, many pain experts have been calling for the development of a Canadian Pain Strategy, which would implement a plan for the prevention, research and education, coordination of care and funding for services for pain management.[139] Experts acknowledge that pain in Canada is poorly managed and that there is a lack of funding for non-pharmacological alternatives. Maria Hudspith, the executive director of the nonprofit organization Pain BC, comments on this gap in her observation, "that's why physicians have been so reliant on medication. They've had one tool in the toolbox that's funded, and it's called a prescription pad."[140] Many frontline primary care providers do not know how to manage their patients' chronic pain because they receive minimal training in how to treat it.[141] One Canadian study from 2009 found that only one third of major universities with health science programs dedicated time to teaching about pain, and that, of the programs that did have pain curriculum, medicine offered a mean of 16 hours of instruction time, whereas occupational therapy and physical therapy offered a mean of 28 and 41 hours, respectively. In veterinary medicine, by way of contrast, the number of hours of instruction time in treating pain is 86, which means that veterinarians receive five times more education for pain than physicians.[142] Subsequently, patients are often

PAIN

Only 1/3 of major universities with health science programs teach about pain.

Of these programs, the mean number of hours of instruction time is

16 HOURS *for medicine*

28 HOURS *for occupational therapy*

41 HOURS *for physical therapy*

86 HOURS *for Veterinary medicine, or five times more education for pain than physicians.*

CMHA believes that creating a National Pain Strategy that includes addictions would allow for more effective training and would better prepare physicians and primary care providers to treat pain in Canada.

referred to pain clinics by their primary care providers where wait times can range from a few months to five years, an option which is often not accessible for people living in rural areas and the north.[143] To effectively manage pain, pain experts suggest that patients need access to a multidisciplinary care team offering a range of treatment strategies that might include non-pharmacological or pharmacological interventions.[144] In recognition of this need, CMHA is currently collaborating with research partners to explore the efficacy of multidisciplinary care teams and their role in pain management and opioid tapering. CMHA also believes that creating a National Pain Strategy that includes addictions would allow for more effective training and would better prepare physicians and primary care providers to treat pain in Canada.

ECHO Ontario is one example of a program that shows promise in transforming the quality of care for chronic pain management. The ECHO program, which stands for Extensions for Community Healthcare Outcomes, uses teleconference technology to create a community of practice linking physicians, nurses, social workers, pharmacists, physiotherapists, occupational therapists and mental health workers from all over Ontario. The resulting learning network facilitates a multidirectional exchange of knowledge on pain management that is based on local needs and real patient cases. In a study exploring the outcomes of ECHO Ontario, primary care providers reported feeling more confident in their abilities to treat their patients' pain and, in some cases, described how they achieved success in "reducing patients' opioid consumption and increasing function."[145] CMHA recommends that pain management education be embedded in continuing medical education for primary care providers and that training should be more thorough than it is at present, particularly for the management of chronic pain.

CMHA believes that a National Pain and Addictions Strategy should also include educating primary care physicians about the intersections among chronic pain, mental health, and addictions. Although chronic pain can exist on its own as a medical condition, it can also be closely linked to mental health: in comparison to other chronic diseases, chronic pain is linked to high rates of depression, anxiety, suicidal thoughts, and suicide.[146] Addiction can also result from opioid use for the treatment of chronic pain. In the long-term treatment of pain with opioids, drug tolerance gradually increases, which means that consumers need higher doses to achieve pain relief, often fostering physical dependence and sometimes addiction.[147] According to the *2017 Canadian Guideline,* there is a 5.5% risk of addiction with the use of opioids, although it has been suggested elsewhere that this is a conservative estimate and that opioid use disorders more likely occur in up to one-third of patients on chronic opioid therapy.[148] Primary health providers should therefore receive appropriate training to recognize and screen for substance use problems, treat concurrent mental health disorders along with chronic pain, and develop an awareness of harm reduction to ensure patient safety.

CMHA recommends that **pain management education be embedded in continuing medical education** *for primary care providers and that* **training should be more thorough** *than it is at present, particularly for the management of chronic pain.*

For patients exploring the possibility of taking opioids to manage chronic pain (also known as "new starts"), Dr. David Juurlink, staff internist and head of

If the treatment plan for managing chronic pain includes a prescription for opioids, it should also include an exit plan.

Clinical Pharmacology and Toxicology at Sunnybrook Health Sciences Centre in Toronto, recommends that physicians carefully weigh the possible benefits and risks of taking opioids in consultation with the patient, and that the physician assess patient history, including history of any concurrent mental health disorders or substance use, in developing a treatment plan. Juurlink also strongly advises that if the treatment plan does include a prescription for opioids, that it should also include an exit plan (e.g. plan for a slow taper).[149] In addition, when prescribing opioids, there are other factors that should be taken into consideration, including polydrug use. Research suggests that the concurrent use of benzodiazepines or other central nervous system (CNS) depressant medicines, including alcohol, in conjunction with opioids poses a higher risk for poisoning.[150] CMHA recommends that physicians continue to educate patients about the risks of the concomitant use of opioids and CNS depressants and that they adhere to the recommendation outlined in the *2017 Canadian Guideline* advising physicians to avoid prescribing benzodiazepines or any other CNS depressant with opioids.[151]

The delisting of high strength formulations of long-acting opioids is another policy intervention that governments have used to curb the prescription opioid crisis, but this strategy also presents unintended consequences. In 2012, when OxyContin was replaced with OxyNeo, a tamper-resistant version of the same medication, that change did not result in a reduction of deaths relating to opioid use. Rather, it contributed to a "substitution effect" whereby consumers switched to using other strong prescription opioids such as hydromorphone and fentanyl.[152] Addictions & Mental Health Ontario and CMHA Ontario note that the decision to delist some high strength opioids may have an impact on low-income and other vulnerable populations, including people on disability support programs, given that a high number of people with disabilities live with mental health and substance use problems. In recognition of these potential harms, CMHA recommends that policymakers consult with low-income Canadians, seniors, Indigenous people, and people receiving disability income supports about the risks and possible outcomes of delisting, and that any proposed medication delistings be accompanied by a strategy for physicians, social workers and peers to support people who are currently using high strength opioids to transition to another treatment plan.[153]

SECTION III:

Harm Reduction

3.1 Increase access to naloxone, an opioid overdose antidote, through changes in current dispensing practices

- Reduce barriers for accessing naloxone by classifying it as an unscheduled medication and offering it free of charge, and ensure that naloxone is consistently available in pharmacies and community-based health organizations across all provinces and territories.
- Provide easier access to naloxone nasal spray by adding it to the national formulary and ensuring it is available to all free of charge.
- Provide access to, and training for naloxone for non-medical staff working in community settings where overdoses occur (e.g. in shelters, temporary housing, drop-in centres, etc.), particularly for First Nations and northern communities where access is currently limited.[154]
- Support prescribers to dispense naloxone to patients at risk of overdose, including pain and opioid substitution patients.[155]

Context and rationale

In 2017, the BC Centre for Disease Control distributed approximately

30,000

naloxone kits and

7,000

of those kits were reported to have reversed an overdose.

Naloxone hydrochloride is a short-acting opioid antagonist that temporarily reverses the effects of opioid poisonings. Delivered by injection (intramuscular, intravenous, or subcutaneous) or intranasally, naloxone, within a few minutes of administration, displaces the opioid at the μ2 receptors in the brain and reverses the respiratory and central nervous system depression caused by opioid poisoning.[156] In the midst of the opioid crisis, and especially with the heightened threat of fatal poisonings from fentanyl and fentanyl analogues, naloxone has been shown to be highly effective as a front-line response for reversing poisonings and reducing the number of opioid-related deaths. In 2017, for instance, the BC Centre for Disease Control distributed approximately 30,000 naloxone kits and 7,000 of those kits were reported to have reversed an overdose.[157]

CMHA is concerned that eligibility requirements for naloxone kits might prevent some vulnerable groups from accessing this life-saving drug.

When the Government of Canada developed its Joint Statement of Action to Address the Opioid Crisis in 2016, it made increased access to naloxone a policy priority. On March 22, 2016, Health Canada removed naloxone from the Prescription Drug List for emergency use outside hospital settings. In most provinces it is now a Schedule II drug, which means that it can be dispensed or sold in pharmacies; B.C. and Alberta, however, have followed a different path by deregulating naloxone and listing it as an unscheduled drug, thus allowing naloxone to be sold anywhere.[158] Most provinces and territories have also developed publicly-funded Take-Home Naloxone (THN) programs to make injectable naloxone available free of charge and provide training on how to administer naloxone. The access points for publicly-funded THN vary by province/territory and can include community pharmacies, correctional facilities, shelters, treatment centres/addictions services, health care centres/walk-in clinics, and other community agencies.

However, while naloxone is more accessible to Canadians than it was in the past, access across the country is uneven. In addition to the variability in access points for publicly-funded THN across the country, almost every province has made THN available through pharmacies, which supply naloxone kits to people who use substances, their friends and family members, and sometimes members of the public. However, not all pharmacies carry naloxone, except in the Northwest Territories and Yukon where naloxone is reported to be available in every pharmacy.[159] In addition, some provinces/territories also have eligibility requirements that need to be met to receive a publicly-funded naloxone kit. In Ontario, for instance, anyone seeking naloxone through a pharmacy must present a valid health card. CMHA is concerned that these eligibility requirements might prevent some vulnerable groups from accessing this life-saving drug.

Naloxone also comes in a nasal spray and is available in Canada under the brand name Narcan™. However, at the time of writing, the spray is excluded from publicly-funded THN programs, except in the Northwest Territories and Ontario.[160] Because of its exclusion from publicly-funded programs, Narcan™ is not accessible to most Canadians because a single box containing two doses costs approximately $145. CMHA is concerned that this exclusion might have implications for the opioid crisis. Although the benefits of the nasal spray in terms of usability among first-line responders and support people are not well-studied, according to Vera Horsman, a nurse at Vancouver's Portland Primary Care Clinic, the nasal spray "could save more lives than the injectable form, because it requires less training and skill to administer." Horsman, who delivers training sessions on injectable naloxone to people who use opioids and front-line responders, reported in a CBC article that many people opt not to take the free naloxone kits offered at the end of the training because "they don't feel that they could effectively perform the injection."[161] Furthermore, the nasal spray is considered to be a safer intervention. In Denver, Colorado, and San Francisco, California, first responders in emergency medical systems (EMS) have been equipped with naloxone nasal spray and have made this route of administration the standard of care for responding to

CMHA recommends that naloxone should be dispensed with opioid prescriptions.

opioid poisonings because it reduces the risk of needle-stick injuries and the transmission of blood-borne diseases.[162]

As noted in the previous section, there is a correlation between prescription opioid dispensing and opioid-related harms, including poisoning.[163] Given that patients taking prescription opioids for chronic pain and substance use disorder face the risk of opioid poisoning, CMHA recommends that naloxone should be dispensed with opioid prescriptions. The US Center for Disease Control currently recommends co-prescribing naloxone to patients who have a higher risk of overdose, who have a substance use disorder, and who are receiving a higher dose of prescription opioids.[164] Research also indicates that dispensing naloxone with prescriptions is effective in reversing opioid poisonings. In a study conducted in San Francisco, California, by Coffin et al., patients with chronic pain who received a prescription for naloxone with their opioid prescriptions had 47% fewer opioid-related emergency department visits per month in the six months following the receipt of prescription, and 63% fewer visits after one year.[165]

3.2 Research and support innovative pilots that offer prescription drugs as an alternative to the contaminated drug supply for people who continue to use illegal drugs because addictions treatment has not worked or because they are not ready for treatment

- Expand the ability of people who use drugs to test their own drugs by ensuring that supervised consumption sites, front-line workers, harm reduction programs and the members of the public in urban and rural areas have access to drug checking tools, including fentanyl test strips.
- Invest in clinical research exploring the effectiveness of drug checking on substance use behaviours and health outcomes for people who use opioids, and explore alternative models to increase effectiveness.
- Continue to issue public alerts when there is evidence of contamination in the drug supply.

CMHA recognizes that the distribution of uncontaminated opioids will likely come with important challenges that will need to be addressed and that this approach is not in itself a solution to the crisis or to opioids addictions.

Context and rationale

In response to the high number of poisonings and deaths from illegal drugs contaminated with unknown and often deadly quantities of fentanyl and fentanyl analogues, many public health workers have been calling for innovative, out of the box and evidence-informed approaches to curb the high number of deaths. As B.C. is the province hardest hit by the crisis, public health officials have proposed that one way forward is to provide people who are at the highest risk of exposure to fentanyl with an uncontaminated, regulated supply of opioids that could be distributed by the government and its partners in health care and social services.

Dr. Mark Tyndall, the director of the UBC Centre for Disease Control, is piloting an innovative program that is supported by Health Canada that will supply hydromorphone pills to people who are at risk of poisoning from fentanyl and fentanyl analogues. Although the details of the pilot have yet to be announced, Tyndall has noted that he is looking at three options for distributing the pills: through vending machines in social housing and other locations with an identified need, at supervised consumption sites, or in pharmacies.[166] When compared with the cost of diacetylmorphine-assisted treatment, which is approximately $27,000 a year, treatment with hydromorphone pills is estimated to be around $700 annually. CMHA recognizes that the distribution of uncontaminated opioids will likely come with important challenges that will need to be addressed and that this approach is not in itself a solution to the crisis or to opioid addictions. However, CMHA is in agreement with Tyndall that a pilot such as this one is “a public-health response, not an addiction-medicine response” to opioid use, and that it is an important mechanism for promoting harm reduction for the people most at risk in this time of crisis.[167]

However, CMHA is in agreement with Tyndall that a pilot such as this one is “a public-health response, not an addiction-medicine response” to opioid use, and that it is an important mechanism for promoting harm reduction for the people most at risk in this time of crisis.

Harm reduction workers are also looking to other substances such as cannabis as an avenue for reducing the harms associated with opioids. In 2017, the High Hopes Foundation created a small booth that is staffed by the Overdose Prevention Society and distributes cannabis capsules, oils and edibles to help curb opioid use. The B.C. Emergency Health Services and the Vancouver Police have publicly stated their support for the High Hopes initiative, recognizing that cannabis presents fewer harms when compared to opioids and that it can be an effective harm reduction tool during the opioid crisis.[168] Given the scarcity of studies that explore cannabis as an alternative to opioids and a harm reduction tool, CMHA recommends that research be conducted in this area.

Drug checking has also been identified as an important harm reduction tool. Drug checking is a service that allows people who use drugs to chemically analyze the contents of their drugs.[169] At this time, there is no clear evidence on the effectiveness of drug checking on substance use behaviours or the health outcomes of people who use drugs.[170] However, there are a few reports available on the number of people who discard their drugs after a

positive test result. Recently, a drug checking pilot at Insite that used low-cost fentanyl strips found that most consumers did not dispose of their drugs after a positive test result. However, they were 10 times more likely to reduce their dose, and of that number, 25% were less likely to overdose.[171] The Insite pilot is recognized as being both cost effective and "promising," and as such, it has been expanded to approximately 25 overdose prevention sites.[172]

Despite the limited evidence at this time, CMHA sees drug checking as a useful harm reduction measure, given that it is often paired with counselling services and provides an opportunity for front-line workers to offer information about harm reduction and treatment services. For example, at music festivals and evening events in Vienna, Austria, a mobile drug checking service known as Checkit! on average tests 100-120 drug samples and provides counselling and information services for 600 drop-ins every night.[173] Furthermore, a recent US study also found that 90% of young people who use illegal substances were willing to use rapid test strips to check their drugs for fentanyl, which suggests that drug checking "might be an acceptable intervention for young adults who use drugs for identifying adulterants in the illicit drug supply."[174] In Canada, however, drug checking is still not widely available, as organizations need an exemption under the *Controlled Drugs and Substances Act* to offer consumers the option to test their own drugs.[175] CMHA strongly recommends expanding access to drug checking services by making testing equipment available to front-line workers and health care providers. We also support BCCSU's recommendation that more drug checking models should be explored, and that test strips should be made "available to vulnerable individuals to use for home drug checking." Seeing as a high number of people are experiencing accidental poisonings in private residences, take-home drug checking will help reach a broader population and circumvent the stigma that can often act as a deterrent to drug checking.[176]

3.3 Build on the success of overdose prevention sites and supervised consumption sites and increase accessibility by providing public education on their effectiveness

- Address the stigma that often acts as a barrier to the establishment of supervised consumption sites and overdose prevention sites.
- Explore alternative models for supervised consumption – i.e. using videoconferencing technology or developing alternative consumption settings – to address the needs of people who use substances alone in private residences.
- Follow best practices for peer employment. Ensure that peers are compensated with fair wages for their expertise and work.[177]

The risk of fatal poisoning is higher for people who consume illegal substances alone at home, given that they lack a peer or support network that can intervene with naloxone.

- Scale up harm reduction services Canada-wide, including in remote and rural areas, and in prisons.[178]
- Develop policy ending parole conditions that prevent recently-released inmates from visiting harm reduction sites ("red zones") or carrying harm reduction supplies.[179]

Context and rationale

While there is a common perception that opioid-related poisonings affect the most marginalized segment of the population that regularly uses drugs, and that the poisonings are occurring on the streets and in alleyways, the reality in Canada is that a significant number of deaths are happening in private homes. The B.C Coroners recently reported that up to 94% of deaths from illegal drugs in January 2018 occurred indoors, with 64.8% of that number occurring in private residences.[180] With the contamination of illegal substances with fentanyl and fentanyl analogues, the risk of poisoning and death is as high for people who use substances recreationally as it is for those who use them on a daily basis. Any Canadian who uses an illegal substance, whether cocaine, methamphetamines, MDMA, heroin, hydromorphone, or fentanyl – even if only occasionally – is at risk of opioid poisoning and possibly death now that fentanyl and fentanyl analogues are being cut into a wide range of illegal substances. In fact, the risk of fatal poisoning is higher for people who consume illegal substances alone at home, given that they lack a peer or support network that can intervene with naloxone. As the number of opioid-related harms continues to rise in Canada, it is imperative that governments and the health care sector address the stigma associated with drug use that often prevents people who use drugs from accessing harm reduction services.

Supervised consumption sites, also referred to as supervised injection sites, are highly effective in reducing the harms associated with drug use. At supervised consumption sites, people who use substances are furnished with sterile equipment for drug consumption, emergency care in the event of poisoning, primary medical care and referral to addictions services in a medically-supervised environment.[181] A qualitative research study found that injecting in public spaces leads to unsafe consumption practices.[182] Supervised consumption sites, however, show evidence in improving health outcomes, especially for people who inject drugs, by reducing the incidences of Hepatitis C Virus (HCV) and HIV, and death associated with poisoning. Supervised consumption sites also have important community and public safety benefits. A study of Vancouver's Insite found that the site's opening correlated with a reduction in public drug use and discarded syringes, and an improvement in public order.[183] Most importantly, however, in B.C., no one has died from an accidental poisoning at any of the province's supervised consumption and overdose prevention sites. In its 20 overdose prevention sites, 66,604 visits were made between December 2016 and March 2017 and 481 overdoses were reversed.[184]

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The success of supervised consumption sites and their greater prevalence in Canada is owed to the activism of people who use drugs in B.C.

However, many Canadian provinces currently do not have life-saving supervised consumption and overdose prevention sites. Supervised consumption sites have significantly expanded in Canada since 2015 from only one site in Vancouver's Downtown Eastside to 21 sites across B.C., Alberta, Ontario and Quebec, and temporary overdose prevention sites have also been established in B.C., Alberta and Ontario to fill the gap during the crisis. Yet, together, supervised consumption and overdose prevention sites are only found in major cities in these four provinces and are absent in Saskatchewan and Manitoba, in the Atlantic provinces and in the northern territories, where community opposition, stigma and a lack of infrastructure continue to operate as barriers to their establishment. In Canada, supervised consumption sites require an exemption under section 56.1 of the federal *Controlled Drug and Substances Act,* and once approved, they are permanent sites. In December 2017, a year after the province of B.C. defied the federal exemption and opened several unsanctioned overdose prevention sites, the federal government moved to allow individual provinces to apply to Health Canada for an exemption from federal regulations to open temporary overdose prevention sites if they identified "an urgent public health need."[185] Overdose prevention sites differ from supervised consumption sites in that the people who operate them may not be health care professionals (e.g. they can be registered nurses, front-line workers, or peers), but they are trained to intervene with naloxone in the event of an accidental poisoning. The federal government also defines overdose prevention sites as an "immediate short-term response to save lives" during the opioid crisis and grants permission for the sites to operate on a limited term of 3-6 months.[186] However, to date, only B.C. and Ontario have taken advantage of loosened federal restrictions to establish overdose prevention sites. As fentanyl and fentanyl analogues continue to move eastward in Canada, CMHA recommends that the federal government continue to work closely with the provinces and their municipalities to facilitate the establishment of new supervised consumption and overdose prevention sites.

Overdose prevention sites differ from supervised consumption sites

in that the people who operate them may not be health care professionals (e.g. they can be registered nurses, front-line workers or peers), but they are trained to intervene with naloxone in the event of an accidental poisoning.

The success of supervised consumption sites and their greater prevalence in Canada is owed to the activism of people who use drugs in B.C. In 1996, the Vancouver Area Network of Drug Users (VANDU), an activist organization founded by people with lived experience (PWLE) with drug use, set up two unsanctioned supervised injection sites which eventually created enough pressure to open Insite, the first government-sanctioned supervised injection site in Canada.[187] Engaging PWLE has been shown to be a very effective measure in promoting harm reduction for people who use illegal substances. PWLE have been leading the way in developing needle distribution programs, educating about harm reduction, supporting initiatives for peers, and facilitating community-based research.[188] PWLE have been shown to "address equity issues to improve the utilization of harm reduction services, making them responsive to the needs of peers," and they can also help promote a better understanding of "local risk environments, including issues related to physical, social and economic environments, which vary between and within health authorities."[189] Given that substance use continues to be stigmatized and criminalized, PWLE can also create a supportive environment

Access to naloxone is particularly important for persons recently released from correctional facilities because they are at a high risk for poisoning if they experience relapse, given that a period of abstinence following opioid use significantly reduces the tolerance levels accrued with prolonged opioid use.

that improves the health outcomes for people who use drugs. However, while the involvement of PWLE is increasing, they are still underutilized in developing harm reduction measures.

Given that there is a high number of people experiencing opioid poisoning alone at home, there is a critical need to develop new and innovative harm reduction approaches to reach this hidden population that uses illegal drugs but is not ready for or comfortable accessing supervised consumption sites or overdose prevention sites. Online forums for people who use substances, which have been around since at least 2001, provide a space for knowledge exchange among peers on safer drug consumption practices and have been recognized as an important harm reduction tool.[190] Similar platforms could be developed, for instance, using videoconferencing technology in online peer-supported forums, to intervene in accidental poisoning events. CMHA recommends consulting with and hiring PWLE to conduct research to identify the needs of this population and explore alternative models for supervised consumption, including the possibility of web-based interventions.

Finally, people who are incarcerated or who have been recently released from correctional facilities are a particularly vulnerable group when it comes to opioid harms. Given that many countries take a punitive stance towards people who use drugs and commit crimes related to their drug use, a large number of people entering the prison system have experience with problematic substance use. Drug use is particularly prevalent in prisons and is considerably riskier because of the absence of sterile equipment for drug consumption, which leads to needle sharing and contributes to higher incidences of HIV and HCV. Furthermore, prisons are experiencing higher rates of poisonings with the contamination of substances with fentanyl and fentanyl analogues. The Alberta Health Services reported that between January 2016 and November 30, 2017, 122 poisonings occurred in Alberta's provincial correctional facilities, 95% of which involved opioids.[191] Furthermore, in a study conducted in Scotland, people who use drugs who were recently released from correctional facilities were found to be eight times more likely to die from poisonings in the two weeks following their release, and in a US study, 53% of former inmates experienced or witnessed an overdose, 64% of which occurred within a month of release.[192] Access to naloxone is particularly important for persons recently released from correctional facilities because they are at a high risk for poisoning if they experience relapse, given that a period of abstinence following opioid use significantly reduces the tolerance levels accrued with prolonged opioid use. The US study recommends that "planning for overdose prevention should be a key component of prison aftercare," and that inmates should be furnished with and trained to use naloxone upon discharge from a corrections institution.[193]

SECTION IV:

Collaboration and Support

4.1 Decriminalize the personal possession of illegal drugs with the goal of aligning Canadian drug laws with public health

Context and rationale

For too long, governments around the world have taken a "punitive anti-drug stance" in the hopes that they could control and eradicate the illegal drug market. In the middle of the twentieth century, many governments, including Canada's, signed on to UN treaties that outlined an international obligation to punish people for possessing and using illegal substances by "establish[ing] as a criminal offense under its domestic law…the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption."[194] However, more organizations and international leaders are beginning to call for the decriminalization of drugs for personal use, as criminalization carries significant costs for the health of people who use drugs, for human rights and for the economies of the very countries that are doing the punishing. Furthermore, there is growing recognition that a public health approach to substance use is not consistent with the criminalization model and that supporting the health and well-being of people who use drugs is an approach backed by scientific evidence.

Evidence suggests that the criminalization of people who use drugs is ineffective. As the Global Commission on Drug Policy points out, criminalization does not result in reduced rates of drug use. Between 2006 and 2013, the number of people who consumed illegal substances globally grew by almost 20% to approximately 246 million people, despite the existence of harsh penalties for drug use in many countries.[195] Criminalization is also overwhelmingly linked to negative health outcomes. In countries where the consumption of illegal substances is punished, higher levels of HIV and HCV abound and there are more barriers when it comes to accessing harm reduction services and sterile supplies.[196] In 2014, when harm reduction was significantly more limited in Canada than it is now, 13,960 people, or 19% of Canadians living with HIV attributed their HIV status to injection drug use.[197] Indigenous people are also disproportionately impacted by the higher HIV rates. They represented 10.8% of all new infections in 2014, and half of these new infections were attributed to injection drug use.[198] Furthermore, in many parts of the world, criminalization has led to human rights violations, given that

DECRIMINALIZATION VS LEGALIZATION

Following decriminalization, the possession, use, and acquisition of illegal drugs are no longer criminal offences. Anyone found with small amounts of drugs in their possession may receive an administrative sanction, such as a referral to treatment or fine. However, producing, supplying and selling drugs remain criminal offences.

Legalization removes prohibitions on drug manufacturing, sales, possession and personal use, although it may impose some regulations, as will be the case for cannabis in Canada.

"significant human rights abuses are carried out in the name of drug control, from the use of the death penalty and extrajudicial killings, to torture, police brutality and inhumane drug treatment programs."[199]

Punitive approaches to substance use also deepen social inequalities by incarcerating people who already face significant burdens of oppression. As the Canadian Drug Policy Coalition states, "harsh drug laws open the door to widespread discrimination against already marginalized groups, particularly drug dependent people, people living in poverty, Indigenous and Black people and women. Federally incarcerated women, for example, are twice as likely as men to be serving a sentence for drug-related offences, with Indigenous and Black women more likely than White women to be in prison for that reason."[200] Incarcerating people for drug-related offences also has destabilizing effects on families. Research indicates that children with a parent in the criminal justice system are more likely to experience negative outcomes, including problems with academic success, substance use, behavioural problems, poverty, stigma, depression and anxiety.[201] Furthermore, incarceration perpetuates the cycle of poverty by negatively affecting employment opportunities and access to housing for those released from correctional facilities. Incarceration thus punishes people for their involvement with drugs without addressing the social conditions that engender that involvement in the first place.[202]

In Canada, a high number of people with substance use disorders and in need of medical care end up entangled with the criminal justice system for using substances or for committing crimes related to their addictions. Possession continues to be the most prevalent drug-related criminal offence in Canada. Out of the 95,400 *Controlled Drugs and Substances Act* offences in 2016, the majority were for possession of cannabis and other drugs, with the number of offences for heroin, methamphetamines, and prescription opioids up by 32%, 22% and 7%, respectively.[203] In addition, a considerable number of people who enter Canadian prisons have problems with substance use. The Office of the Correctional Investigator reported that in 2014, 80% of federally-sentenced offenders had problems with substance use, and over half reported their crime(s) to have been linked to their substance use.[204]

Contrary to the logic of criminalization, incarceration does not result in the cessation of substance use, nor does it prevent harm. According to one survey, 17% of male federal inmates and 14% of female federal inmates injected substances in prison. Of those inmates, half shared injection supplies with people who were infected with HIV, HCV or whose infection status was unknown.[205] The HIV rates among federal prisoners are 10 times higher than the rest of the Canadian population, and HCV rates are 30 to 39 times higher.[206] In fact, incarceration poses a significant barrier to recovery from substance use disorders, given that access to treatment is often limited for Canadians behind bars.[207]

Evidence strongly suggests that policies that punish and criminalize people who use illegal substances are ineffective, and that a new approach is needed to treat people who experience problematic substance use.

This evidence strongly suggests that policies that punish and criminalize people who use illegal substances are ineffective, and that a new approach is needed to treat people who experience problematic substance use. Recognizing that a public health approach to drug use is needed, many international leaders and organizations are now calling for the decriminalization of illegal substances for personal use. Decriminalization has been endorsed by the UN and other international organizations, including UNAIDS, the World Health Organization and the Global Commission on Drug Policy. In Canada, the Canadian Public Health Association, the Canadian Drug Policy Coalition, the UBC Centre for Disease Control, the Canadian Association of Social Workers and the Canadian HIV/AIDS Legal Network are only a few of the organizations that are calling for decriminalization.[208]

There is good evidence to show that decriminalization can work in the service of public health. In 2001, Portugal decriminalized illegal substances for personal use. In doing so, Portugal eliminated criminal penalties for low-level possession and established a system in which people found with small amounts of illegal substances are issued an administrative sanction rather than a criminal offence. Although prohibition is still the rule in Portugal, sanctions for the possession and consumption of substances are no longer part of the framework of criminal law in that country.[209] If police stop someone who is using or is in possession of illegal substances, they will issue an administrative sanction and ask that they appear before a Dissuasion Commission, which is comprised of a legal expert, a health professional and a social worker.[210] The law is designed to encourage rather than force treatment upon people who use substances.[211] The purpose of decriminalizing substance use in Portugal was thus intended to redirect resources to prevention, improve the quality and access to treatment services for people with substance use problems and provide voluntary treatment as an alternative to prison sentences.[212] This emphasis on treatment and improving health outcomes is reflected in policymakers' decision to move responsibility for drug policy from the Ministry of Justice to the Ministry of Health.[213] Given that drugs are decriminalized and not legalized in Portugal, however, trafficking is still punishable and can result in a prison sentence of four to 12 years.[214]

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60% **INCREASE** *in the number accessing treatment for substance use.*

A critical learning for Canada from Portugal is that decriminalization is reported to have reduced fear of accessing treatment. Portuguese drug officials have noted that before decriminalization, there was widespread fear among people who used substances that they could be arrested and prosecuted if they attempted to access treatment, particularly through state agencies.[215] Officials believed that in decriminalizing illegal substances, they could remove the fear of, and stigma associated with, receiving a criminal conviction, while creating a pathway for better treatment access. Since decriminalization, Portugal has seen a 60% decrease in the number of people arrested and sent to criminal courts for drug offences, and a 60% increase in the number accessing treatment for substance use.[216] Furthermore, the reforms in Portugal included a plan to increase the availability of treatment,

We believe that decriminalization will help treat problematic substance use as a health issue rather than a criminal one, will redirect resources from the criminal justice system into health care and will begin to address the stigma that acts as a barrier to treatment.

which resulted in 26 additional outpatient treatment centres, adding to the 53 centres already in existence.[217] Drug overdoses have also declined; while the rate of drug overdose deaths in 2015 was 20.3 per million citizens in the European Union, in Portugal it was 5.8.[218]

In countries like Canada, where the consumption of illegal substances continues to be criminalized, people with lived experience of substance use are telling policy makers that decriminalization is absolutely necessary for facilitating treatment and reducing stigma. Jordan Westfall, president of the Canadian Association of People Who Use Drugs, notes that "without some kind of decriminalization, without making people feel safe enough to access services, to access treatment, we cannot get out of this epidemic. We really need to rethink our entire drug policy."[219]

Given that decriminalization can result in better access to treatment and improve health outcomes for people who use substances, CMHA recommends that Canada decriminalize all illegal substances for personal use. We believe that decriminalization will help treat problematic substance use as a health issue rather than a criminal one, will redirect resources from the criminal justice system into health care and will begin to address the stigma that acts as a barrier to treatment. We also recommend that, if administrative sanctions are part of Canada's decriminalization policy as they are in Portugal, treatment should be voluntary and support the recovery of people who use drugs with wrap-around services. There is a lack of evidence supporting the effectiveness of compulsory addictions treatment, and growing evidence that voluntary treatment improves the health outcomes for people who use substances. In addition, there are potential human rights abuses associated with compulsory treatment. In light of these facts, CMHA therefore advises policymakers to develop decriminalization policy that promotes evidence-based voluntary treatment to reduce the harms associated with substance use.[220]

CONCLUSION:
The Way Forward

Since the Government of Canada introduced the Canadian Drugs and Substances Strategy in 2016 and reinstated harm reduction as a core pillar, stakeholders from across the country have made significant strides in developing and expanding programs and initiatives that are having real impacts in the lives of Canadians who use substances or whose lives are affected by someone who does. These measures lay the foundation for a public health approach to an emergency that originates from the suffering of many Canadians who experience structural inequalities, untreated pain, mental illness and addictions challenges. However, even with the expansion of harm reduction and treatment measures, the opioid crisis in Canada continues to escalate every year. The recommendations in this paper suggest that effectively tackling an emergency as urgent and complex as the opioid crisis will require strong intersectoral collaboration among different levels of government, public health agencies, researchers and community-based service providers.

The recommendations included here call for greater investments in treatment, better coordination of services, including aftercare and wrap-around services, funding for a continuum of community-based mental health and addictions services, investment in health promotion and the social determinants of health, investments in innovative and evidence-informed harm reduction projects and support for initiatives that reduce stigma. As many Canadians face systemic barriers due to social exclusion, programs and services also need to be attuned to the needs of vulnerable populations, including women, mothers, Indigenous people, people with disabilities, seniors, children and youth, people with disabilities, people of colour, immigrants and refugees. We also believe that a public health approach for curbing the high number of harms caused by opioids necessitates the decriminalization of illegal substances, an approach which we believe will promote the health and well-being of people who use substances and facilitate their entry into treatment.

CMHA is well-positioned to work with the federal and provincial/territorial governments to provide research, policy and program support oriented to mental health and addictions. Across Canada, CMHA branches, regions and divisions provide a wide range of mental health and addictions services, from supportive housing to counseling and clinical services. With branches in 330 communities across Canada, we are well-integrated into the communities that we serve and can be a strong partner in delivering services that will meet the mental health needs and facilitate the recovery of people who face mental health and addictions challenges. CMHA looks forward to working with the federal government to design effective policies and programs that curb the escalating crisis and promote public health for all Canadians.

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