Interior Health

The Toxic Drug Crisis in BC's Southern Interior Region

2022 Medical Health Officer Report Part 2

Contents

In this report, the term Southern Interior region of British Columbia is used to refer to the large geographical area across which Interior Health provides health and wellness services, and works together with partners and communities.

Message from Dr. Carol Fenton
Medical Health Officer

The public health emergency due to substance poisoning deaths in B.C. is ongoing and continues to worsen in B.C.'s Southern Interior. This is the second part of a two-part medical health officer (MHO) report series on the toxic substance crisis in the Southern Interior region of B.C.

I believe that to solve a problem, we must understand it. What I want to achieve with this second report is to delve deeper and explore the why: Why are people dying from substance use? Why do people use substances?

This report will explore some of the data related to the toxic drug crisis. These aren't just statistics and numbers, however; these are people we know and love. They are people in our families, people we work with, our neighbours and our friends. We receive reports every month on the number of people who have lost their lives needlessly. This is extremely hard for families, communities and frontline workers as they face this challenge.

It is distressing that despite investment, expansion and preventive measures, the crisis continues to worsen rather than improve.

While I believe that we need to focus on the value of the lives we can save, if we talk only about reducing the number of deaths, this problem will not be solved. We need to also move upstream. A lot of people use substances for a variety of reasons. The risks to health can come from the substances themselves, but they can also come from the way they are used, and the consequences the use behaviour can have on one's life and relationships – these would all be considered high-risk substance use.

We live in a society that generates conditions and situations that can lead people to high-risk substance use. The paths are complex, and people end up on a path in many ways, and that's why this problem is so wicked. The second half of this report explores all the different types of interventions that are needed, presented using an upstream analogy, to understand how all the pieces fit together to support a healthy society with members who have healthy relationships with themselves, each other and psychoactive substances.

Executive Summary

The unregulated substance poisoning crisis continues to worsen

This public health emergency in B.C. was declared in April 2016, and has continued to worsen since the onset of the COVID-19 pandemic. Twenty twenty-two was the deadliest year ever across B.C.'s Southern Interior.

Impacts of the COVID-19 pandemic

From 2016 to 2019, concerted efforts to save lives through interventions like naloxone training, overdose prevention sites and opioid agonist therapy (OAT) seemed to be making a difference, with a significant decrease in deaths in 2019. This progress was undone with the onset of the pandemic in 2020.

Part 1 of this report detailed some of the reasons why the drug supply has become increasingly toxic.

Part 2 seeks to combat stigma through a deeper understanding of people who use substances, and focus on prevention.

Key findings from the chart review

This review of medical charts included 210 people who died from substance poisoning between July 2021 and April 2022, and had accessed Interior Health (IH) health-care services in the year before their death. Key findings included:

HEALTH EQUITY

Documented barriers to access, trauma, social deprivation and marginalization, material deprivation, and mismatch between individual needs and health system supports.

"Social status seems to affect health service delivery."

"It feels like we held people with open hands and then they fell through our fingers."

-Peer Focus Groups, 2022

"If you have a history of addiction, doctors won't prescribe the medicine you need. That's why no one brings up their substance use [to doctors/to the ER]. Afterwards, everything you do is seen as drug seeking."

-Peer Focus Groups, 2022

EMERGENCY CARE

Just under one in five people had visited an emergency department in the two weeks prior to their fatal substance poisoning event. Most reasons included wounds, injuries and pain, as well as substance misuse.

There are many reasons why people may use substances

One of the main challenges we face when addressing this public health emergency is the stigma associated with substance use that is directed at people who use substances. The reasons why people use substances and the impact of these substances, whether legal or illegal, depend on individual factors and life circumstances.

To feel good

To feel better mentally

To feel better physically

Substance use disorder

Additional reasons First Nations, Métis and Inuit people may use substances include distinct experiences of racism in health care, historical and ongoing colonialism resulting in intergenerational trauma, experiences of violence, and disconnection from identity, culture, community, family and land.

Moving upstream prevents harm and suffering, and improves health and quality of life for everyone

This report uses the analogy of a river to describe the continuum of prevention, from upstream interventions that create the conditions for health and wellness (e.g., healthy public policy), through downstream care services that prevent severe outcomes, including hospitalization and death (e.g., substitute prescribing). At all levels of prevention, a harm reduction approach uses compassion and understanding to keep people as safe as possible, while respecting their human rights and dignity.

Recommendations

By talking to people with lived or living experiences and learning from the medical charts of those who passed, we can better understand what factors are important in their experiences, and the opportunities we have to support them better and keep them alive. We recommend that:

EVERYONE reflects on the perspectives of people who have lived the experiences presented in this report, and commits to anti-stigma and anti-racism work within yourself, your family, your community and your workplace.

INTERIOR HEALTH takes deliberate action to counteract stigma in health-care settings, designs next steps with First Nations and Métis partners, acts on recommendations from the chart review project, and strengthens its approach to the unregulated substance poisoning crisis with a refreshed, comprehensive plan.

BC GOVERNMENT shifts focus upstream, including housing and transportation, and implements recommendations from the BC Coroners Service Death Review Panel report.

Acknowledgements

Interior Health (IH) provides health and wellness services across the ancestral, unceded and traditional territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, Syilx and Tŝilhqot'in Nations. We honour the First Nations as the traditional stewards of these lands and waters.

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The Chart Review Project Team included Jessica Bridgeman, Whitney Chanter, Gillian Frosst, Kasie Gale, Barbara Gauthier, Dr. Karin Goodison, Andrew Kerr, Leanne Cusack, Alison Ko, Danielle Kreutzer, Penny (Lane) Macdonald, Julian Mallinson and Amanda Perrey.

Notes on Terminology

In many spaces, the term ‘Indigenous’ has increasingly replaced the term ‘Aboriginal.’ For consistency with source material, the term ‘Indigenous’ is used throughout this report unless referring to specific ‘Aboriginal’ programs or policies.

Whenever possible, we distinguish between First Nations, Métis and Inuit, recognizing that they are distinct Peoples with unique cultures, histories, rights, laws and governments, with specific rights, interests, priorities and concerns. (1)

The official terminology used for the 2016 public health emergency is the ‘opioid overdose emergency.’ We have evolved to using terms such as ‘toxic drug crisis,’ ‘unregulated drug poisoning emergency’ or ‘unintentional illicit drug toxicity’ to better describe the cause of these deaths.

Throughout this report, you will notice both the use of the term ‘drug(s)’ and ‘substance(s)’ to refer to substances that have a psychoactive effect. These include both legal substances (caffeine, alcohol, cannabis, nicotine, prescribed opioids, benzodiazepines and amphetamines, etc.), as well as illegal/illicit substances (non-prescribed opioids, benzodiazepines, amphetamines, etc.).

To keep language more neutral, deaths as a result of contaminated, unpredictable and unregulated substance supply are referred to as ‘unregulated substance poisoning death.’

Trigger Warning

The report includes information related to unregulated substance poisoning deaths. We recognize that this content and subject matter may be triggering and cause trauma to readers. Please find the right time and space where you are ready to engage with the material before you proceed, and care for your safety and wellbeing. For crisis support, please call:

Interior Crisis Line Network: 1-888-353-2273
For immediate and urgent mental health assistance.

KUU-US Crisis Line Society: 1-800-588-8717
For First Nations, Métis and Inuit Peoples, these crisis response personnel are certified and trained in Indigenous cultural safety.

Métis Crisis Line: 1-833-638-4722
24/7 crisis line by Métis Nation British Columbia and KUU-US Crisis Services
Métis Nation BC also offers 10 counselling sessions to Métis citizens of all ages in B.C. with a registered clinician of their choice.

Métis Lifeguard phone app
www.mnbc.ca/news/2021/metis-nation-bc-launches-life-saving-technology/

Introduction

The unregulated substance poisoning crisis has been a public health emergency in B.C. since April 2016, and has dramatically worsened since the onset of the COVID-19 pandemic.

In 2022, we saw the deadliest year ever across B.C.'s Southern Interior. Part 1 of this report detailed some of the reasons why the drug supply has become increasingly toxic. Part 2 seeks a deeper understanding of the reasons people use substances and their unmet needs, and the barriers and stigma they encounter when seeking help. In focus groups, we talked to people with lived and living experiences in B.C.'s Southern Interior, and we present results from reviewing health records of people who died from substance poisoning.

We can only solve a problem if we understand it. With a better understanding of the causes of substance use, as well as the risk factors for problematic use and use disorders, we can ensure that our solutions match the problem, and we can be effective in this emergency. I present a framework with the upstream analogy to understand how we can organize our efforts in saving and improving lives.

Part 1 Summary

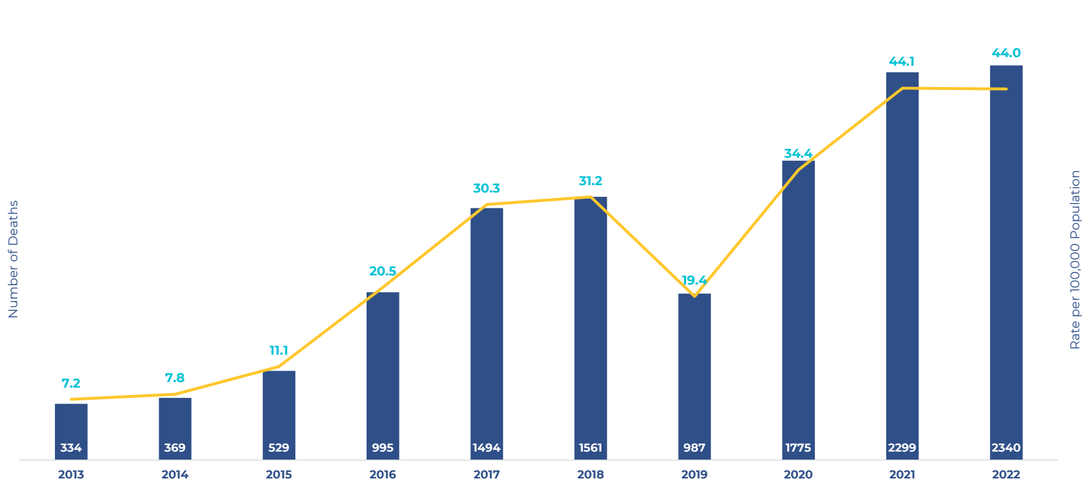
Part 1 of this report described the population health impacts of the toxic drug supply, reported on the results of a chart review of people who died before the pandemic began, and highlighted the many interventions already underway within the health-care system. Key points included:

- Toxic drug deaths in the Southern Interior region were about 10 times higher in 2021 (372) than in 2011 (38). The increasing trend in deaths is similar across B.C. health authorities.
- Drug toxicity is the third biggest cause of potential years of life lost in Interior Health, reflecting the impact on younger age groups.
- Certain population groups are disproportionately impacted by drug toxicity, including younger males and people who self-identified as Aboriginal. The historical context of these impacts for Indigenous Peoples, including past and present trauma, racism, power imbalance and colonization, need to be explored further with First Nations and Métis partners.
- The drug supply has become increasingly toxic for multiple reasons, including the increasing occurrence and higher concentrations of fentanyl and fentanyl analogues in drug products.
- The pre-COVID-19 chart review found that emergency departments were important contact points for people at risk of drug poisoning, that some people had experienced substance-use related stigma, and that people use substances for various intersecting reasons.
- Toxic drug deaths continue to increase despite the expansion and diversification of substance use services. Reducing the risk factors that contribute to drug poisoning and death, and enhancing the protective factors, requires a whole society effort.

Part 2 identifies opportunities for prevention at all stages of a person's substance use journey. This report brings particular attention to the population health approach, including efforts to address the underlying determinants of health and shift investments upstream. This approach is an integral part of a complex system of programs and partnerships that need to work together at every level to end the substance use poisoning crisis.

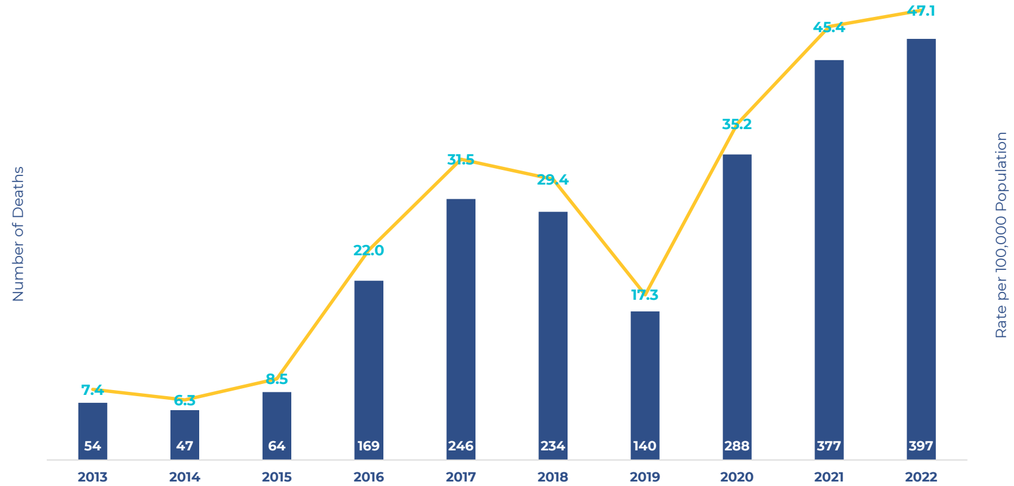
Impacts of the COVID-19 Pandemic

Figure 1. Unregulated Drug Deaths and Death Rate in B.C, 2013-2022.



Source: BC Coroners Service
www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

Figure 2. Unregulated Drug Deaths and Death Rate in the Interior Health Authority Region, 2013-2022.



Source: BC Coroners Service
www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

Since 2019, we have seen a dramatic increase in unregulated substance poisoning deaths.

In Figures 1 and 2, you can see an increase from 2013 to 2016 which triggered the declaration of the public health emergency. Concerted efforts to save lives through interventions like naloxone training and overdose prevention sites seemed to be making a difference, as witnessed by the significant decrease of deaths we saw in 2019. However, all that progress was undone with the onset of the pandemic in 2020. For more details about the reasons and impacts for the increasing toxicity of unregulated substances, see Part 1 of this report, and the BC Coroners Service Death Review Panel report (2).

The substance poisoning emergency disproportionately impacts First Nations and Métis Peoples. For information relating to First Nations people, please see the First Nations and the Toxic Drug Poisoning Crisis in BC report (3).

IH Chart Review Update

A team at IH reviewed the health records from people who died from unregulated substance poisonings between July 2021 and April 2022. The team aimed to learn about their interactions with IH health-care services within two years leading up to their death, and barriers to service such as experiencing stigma associated with substance use.

Eligibility:

All people who died from unregulated substance poisoning in IH between July 1, 2021 and April 30, 2022 (as identified by BC Coroners Service), had a B.C. Personal Health Number, and had accessed any IH service within one year prior to death.

Project Sample:

328

Total number of people who died within the review period

27%

Percentage of people (328) that self-identified as Aboriginal

210

Number of people eligible and reviewed (64 per cent of total)

The personal reflections of the chart reviewers and peer advisor involved in the review are described and illustrated in this Paper People animation.

Video 1: Paper People Animation: Final Version. Created for Interior Health BC March 2023.

(vimeo.com) https://vimeo.com/807956312/2a492716ef

KEY THEMES

Documentation of trauma

From physical and emotional injuries, early childhood trauma, grief and multi-system injury.

Documentation of social deprivation/marginalization

Lacking a sense of connection to family, friends and community.

Documentation of material deprivation

Lacking access to essential needs, which can impact the ability to obtain childcare to attend health appointments, or access medicine and wound care equipment, for example.

Comments on patient behaviours and choices in the medical chart

- Likely informed by the charting person's worldview, stigma and/or racism
- May indicate a mismatch between the needs and wants of the individuals, and what the health system is providing:
  - Documentation of behaviours due to withdrawal likely precipitated by multiple doses of naloxone in response to an overdose
  - Documentation of individuals who may be unable to self-regulate emotions due to cognitive delays or brain injuries
  - Documentation of instances of people repeatedly declining the treatment options that were presented, and expressing interest in options that were not available

Determinants of health

The remarks from the Chart Review Team illustrate the influence of the determinants of health on income, social networks and access to health services on our health outcomes:

"Social status seems to affect health service delivery."

"It feels like we held people with open hands and then they fell through our fingers."

-Peer Focus Groups, 2022

KEY THEMES

Barriers to service

The percentage of individuals with evidence of experiencing **barriers to accessing services** in their medical records has almost tripled since pre-pandemic (36 per cent July 2021–April 2022 vs. 13 per cent Nov. 2017–Oct. 2019).

Examples seen in the chart review:
17 per cent had **lack of phone** and
17 per cent had **long appointment wait times** as barriers to service.

Additional barriers include **limited hours of operation** (nine per cent) and **transportation** to services (15 per cent).

Although lack of transportation is an issue in both urban and rural places; rural and remote communities are disproportionately affected, particularly First Nations communities relegated to remote areas through colonization.

"[Having] no vehicle makes it hard to see a doctor then go fill a prescription. My drug dealer delivers to my house."

"Where I live in the East Kootenays it's easier to get to some services in Alberta than it is to reach them in our own province."

"If you have a history of addiction, doctors won't prescribe the medicine you need. That's why no one brings up their substance use [to doctors/to the ER]. Afterwards, everything you do is seen as drug seeking."

A substance use program client provides insight into why people who use substances may not disclose their substance use history with health professionals.

Only one in seven of those who died from toxic substances had a documented discussion with their health-care provider about harm reduction strategies in their chart.

Emergency department (ED) visits

When examining charts from people who died from unregulated substance poisonings, almost **one in five** (18 per cent) had visited an ED in the **two weeks prior** to their fatal substance poisoning event. An additional 35 per cent had visited an ED between two weeks and three months prior.

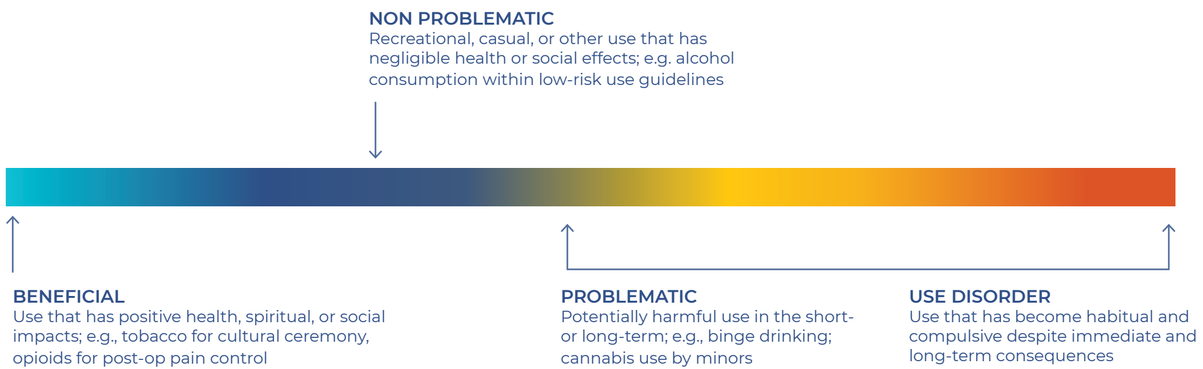
Reasons for ED visits included:

- One in five (21 per cent) individuals had an ED visit related to **wounds/injuries**.
- About a third of individuals had at least one ED visit **due to pain** in the year prior to their fatal substance toxicity event.
    - There is evidence that about one in ten individuals (10 per cent) had **multiple** ED visits **related to pain** in the year prior to their death.
- Only 16 per cent of individuals went to the ED for something related to substance use in the three months prior to their death.

Why Do People Use Substances?

One of the main challenges we face when addressing this public health emergency is the stigma associated with substance use directed at people who use substances. All psychoactive substance use, whether legal (caffeine, alcohol, cannabis, etc.), or illegal, can fall along a spectrum, from beneficial use to use disorder, depending on individual factors and life circumstances. It is important to note that regardless of substance, only a minority of people (10–30 per cent) qualify as someone with a use disorder (4).

Figure 3. The Spectrum of Substance Use



Source: Adapted from British Columbia Centre on Substance Use Addiction Care and Treatment Online Certificate module

Currently, the unregulated street supply of substances is toxic and can poison someone regardless of whether they are using for the first time, occasionally or regularly. People continue to use these substances despite the known risk, so their reason(s) for using substances are important to consider if we want to decrease the risks associated with substance use. To get a good understanding from people with lived and living experiences (peers), we held two focus groups in Summer 2022 to talk about the reasons they started or continued to use drugs, and their experiences.

Eligibility:

People with lived and living experiences (peers) who provide consultation services to Interior Health through the Peer Advisory Group

Project Sample:

- Eight individual peers participated
- Communities included Kelowna, Vernon, Penticton and Kamloops
- Two identified as Aboriginal
- Six females, two males

A peer highlights: "There are a lot of users in hiding who work and have jobs. It's not just a homeless problem, but it seems people focus on that and I'm not sure why."

Figure 4. Word cloud highlighting the most frequent reasons for using substances among peers who participated in focus groups

Source: Peer Focus Groups, 2022

There are many reasons why people may use substances. Peers who participated in focus groups, and clients accessing IH's substance use programs, share these reasons for starting or continuing to use substances:

TO FEEL GOOD – To have a good time with peers, peer pressure, something to do, it's available, others are doing it (peers or in the media), to enhance the experience of other things, curiosity, to feel a sense of belonging

"For me, one of the main reasons...was when I went into high school, it was a completely new world. The people who were smoking cigarettes and pot were the easiest people to get into the group with. So, I started smoking to feel like I belonged in their group."

TO FEEL BETTER MENTALLY – Self-medicating mental health conditions, to cope with past, present, and intergenerational trauma, to feel better mentally, to escape certain feelings or experiences, to function, to numb pain and maintain composure and dignity

"I stay an active user 'cause I'm not ready to deal with my psychological issues."

TO FEEL BETTER PHYSICALLY - Many substances, such as opioids, are effective pain medications. Other types of substances (alcohol, crystal meth, cocaine, etc.) can also treat physical pain, at least temporarily, by working in different ways

"[I have a] broken back and nothing numbs the pain."

"To manage acute pain due to injury and being prescribed an opiate. Once a doctor stops prescribing, you turn to street drugs."

Peers and clients also described their experiences in the problematic and use disorder end of the substance use spectrum. Here are some of their thoughts and experiences:

SUBSTANCE USE DISORDER – A physical and psychological disorder that is often lifelong. Physical dependence happens when the body gets used to substances and builds a tolerance, so more is needed over time to achieve the same effect. Then the body gets used to having it on board and will go into withdrawal when it's not there. Substance use disorder is also characterized by cravings or strong desire to use the substance, and compulsion to continue using despite negative consequences.

"It's like I blinked and I needed it, it wasn't a want anymore."

The psychological aspect of the disorder is multifactorial. There can be reassurance from, and enjoyment of, the ritual of substance use (for example, a feeling of thrill from tracking something down, or benefits and supports from the social group that uses together).

"The activity of finding and using drugs was a distraction and coping, the activity was part of the addiction."

Substance use disorder is on the harmful end of the substance use spectrum: the harms from both the substance use, and the social consequences of using, create problems for the person and their families and communities.

Harms Associated with Substances

The consensus in the focus group was that substances were effective for the reasons that people took them. However, there are also risks to using substances for all these reasons:

When we look at the harms listed, consider how many of them are directly from the substance, and how many are from the stigma and illegal status of the substance.

Toxic unregulated street supply:

The unregulated nature of the illegal market is such that you cannot be certain of the contents of street substances unless they are tested. We are seeing an increasingly unpredictable street supply mixed with other substances like benzodiazepines.

Risk of use disorder:

People can become addicted to many different substances or behaviours. The risk is that when someone is taking substances to manage an existing problem and the substances' effectiveness goes away as the body builds tolerance, then the use disorder becomes a new problem, in addition to the first problem.

Mismatch between the problem and the solution:

The problem may be self-treated by an individual who has not had access to prevention services or appropriate treatment for their problem. Their health issues may include mental pain and physical pain, and they have not been offered services and treatments which address their problem effectively. The person may therefore use substances for self-care, which may partially treat the problem. But other solutions may or will likely work better to address the underlying health issues (e.g., appropriate pain management, counselling, connection to culture, and other supportive services).

Criminalization

and the harms related to incarceration and criminal records.

Stigma:

Keeps people from accessing harm reduction supplies, services and help.

Both stigma

and the **illegal status of substances** increases the risk of people who use substances experiencing violence.

Disruption to family

and social support from stigma, criminalization, and use disorder-related behaviours.

Indigenous Perspectives on Factors Contributing to Substance Use

Working alongside Indigenous communities and organizations, sharing space with Indigenous Elders, peers and service providers, and hearing directly from Indigenous community members who have faced the loss of family and friends due to the unregulated substance poisoning crisis have helped to inform this section of the report.

Indigenous Peoples are over-represented in the toxic drug crisis, with First Nations individuals making up 16 per cent of toxic drug deaths in the Interior of B.C., while representing only four per cent of the entire Southern Interior region population (note: data for Métis and Inuit people were not available at the time of this report) (3). When considering this, it is imperative that we recognize that Indigenous Peoples are not disproportionally affected by the toxic drug crisis due to their identity as First Nations, Métis or Inuit. Instead, it is the harmful colonial practices and policies that were established by the Canadian government, with the goal that Indigenous Peoples be “eradicated as distinct nations and cultures” through the assimilation and elimination of Indigenous Peoples and culture, that contribute to substance use (5).

Indigenous Peoples may use substances for the same reasons outlined above; however, there are additional reasons specific to their distinct experiences as First Nations, Métis and Inuit Peoples that may also contribute to substance use. Some of these factors include:

Experiences of racism in health care

The recent In Plain Sight Report (2020) (6) highlights what Indigenous Peoples have always known: that health-care settings in B.C. are yet another place where systemic racism continues. Experiences of racism faced by individuals and/or their family members, often resulting in inadequate and harmful care, have generated feelings of distrust towards the health-care system.

Racism, compounded by the stigma associated with substance use, has led many Indigenous Peoples to avoid health care, including mental health and substance use services, until their medical needs are life threatening or result in loss of life.

Trauma

Trauma is a significant factor that can lead to substance use, which acts as a coping mechanism to help manage the emotional, spiritual, mental and physical pain caused by experiences of trauma. Many Indigenous people have and continue to experience ongoing traumas due to racism and colonization which has had devastating impacts on Indigenous Peoples' health through forcible displacement from their land, loss of traditional food sources, and disconnection from culture, family and community, ceremony, language, knowledge, and traditions. Furthermore, these traumas are often felt on a community level as Indigenous Peoples often live in smaller, tightknit communities.

An example of this is the collective trauma experienced by many Indigenous Peoples as they continue to confirm the presence of children's bodies at Indian Residential Schools across Canada. Although many Canadians believe that colonial practices are a thing of the past, this is simply not true: colonialism continues to be embedded into our laws, policies and daily lives.

Experiences of violence

Due to racism, discrimination and lateral violence, Indigenous Peoples are more likely to be victims of violence and injury requiring pain control.

Stereotypes about Indigenous Peoples and substance use can contribute to medical professionals overlooking and misdiagnosing pain-related medical needs as drug seeking.

This leaves patients no other option but to seek pain control through other means.

Disconnection from identity, culture, community/family and land

Colonial practices, such as the Indian Act, land displacement, Indian Residential Schools, Day/Mission schools, forced medical procedures, and the Sixties Scoop and Millennium Scoop, aim(ed) to separate First Nations, Métis and Inuit Peoples from their identity, culture, traditional healing practices, ceremonies, laws, and ways of knowing and being in the world, and have resulted in adverse health outcomes for some, including harms associated with substance use.

For many Indigenous Peoples, connection to culture and connection to their own unique and collective identity as First Nations, Métis and Inuit are determinants of health that can decrease the likelihood of negative health outcomes, including those from substance use (7; 8).

Moving Forward

"You know," he said, "sometimes it feels like this. There I am standing by the shore of a swiftly flowing river and I hear the cry of a drowning man.

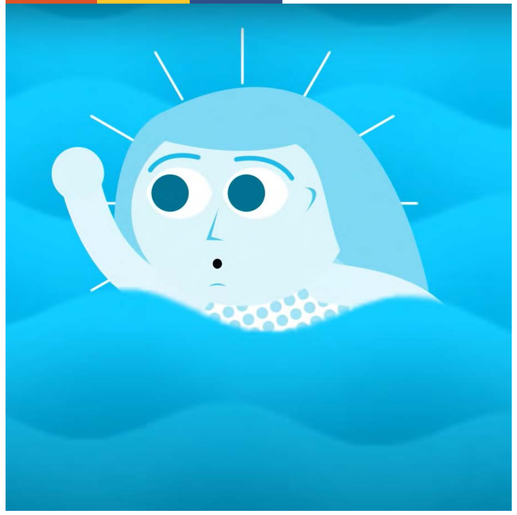
So I jump into the river, put my arms around him, pull him to shore and apply artificial respiration.

Just when he begins to breathe, there is another cry for help. So I jump into the river, reach him, pull him to shore, apply artificial respiration, and then just as he begins to breathe, another cry for help.

So back in the river again, reaching, pulling, applying, breathing and then another yell. Again and again, without end, goes the sequence.

You know, I am so busy jumping in, pulling them to shore, applying artificial respiration, that I have no time to see who the hell is upstream pushing them all in."

-I.k. Zola [9]



Video 2: Video introducing to upstream action to create healthy societies and healthy people.

Source: www.youtube.com/watch?v=qarQXqKbmLg

From the literature, the focus groups, and our work with communities and people with lived experiences, we understand that people have reasons for starting or continuing to use substances. This is important because, to reduce substance use while the illegal supply remains poisoned, as well as to reduce problematic substance use and use disorders, we need to provide healthy alternatives, solutions and support for the issues that people are using substances to address. Having a better understanding of what the needs are empowers us to create solutions that can work to reduce harmful substance use.

In the previous section, we explored the reasons why people begin or continue to use substances. In the context of the substance poisoning crisis, saving lives from substance poisoning is like fishing people out of the river as they are drowning. While it's critically important that we save drowning people, we could make a big difference for people, as well as the workers saving them, if we can prevent people from falling in the river in the first place.

This river analogy helps us understand different levels of intervention along the causal pathways of substance use. This continuum of prevention includes upstream interventions that create the conditions for health and wellness at a population level (e.g., healthy public policy), through downstream care services that prevent severe outcomes, including hospitalization and death (e.g., substitute prescribing). Moving upstream not only prevents harm and suffering, but also improves the overall health and quality of life for everybody. Other examples of intervention across the prevention continuum are included in Appendix A. The range of substance use services in IH were described in Part 1 of this report.

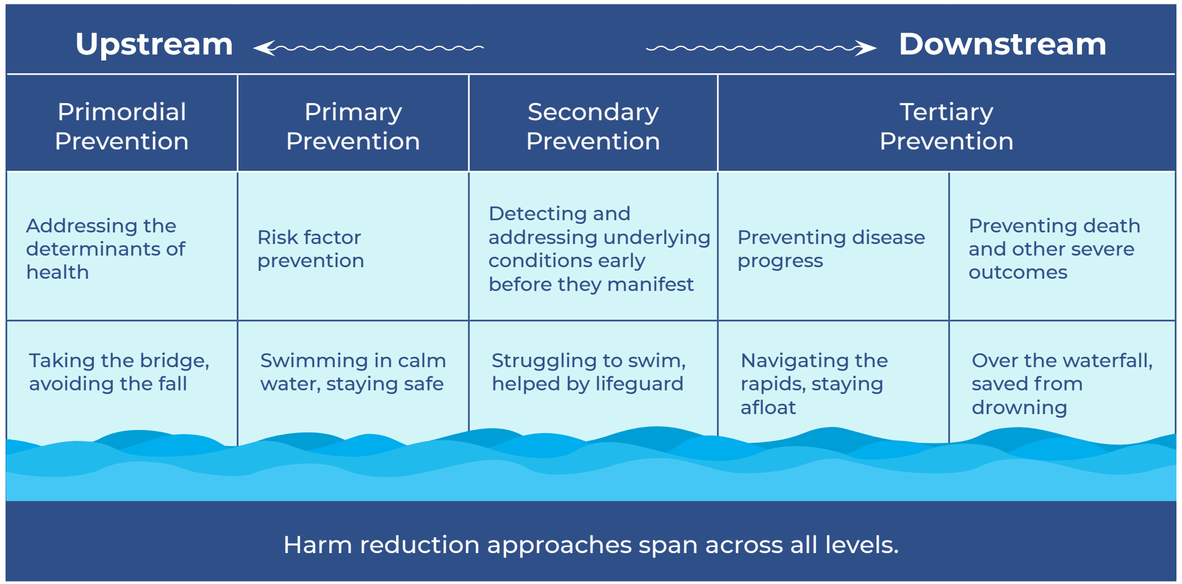


Figure 5. Summary of prevention continuum, alongside conditions in the river analogy

Primordial prevention: Addressing the determinants of health

Primordial prevention addresses the determinants of health. The determinants of health are the farthest upstream environmental, cultural and personal conditions that influence one's health.

If all the determinants of health were supportive, most people would be able to live their healthiest lives. The upstream analogy here would be to build a bridge over the stream so people can travel across safely without falling in.

Figure 6. Image of primordial prevention analogy – a bridge over the river

Source: https://www.flickr.com/photos/marcelocampi/13044851254/

Determinants of Health

Figure 7. Infographic of the Determinants of Health

Source: Compiled from Public Health Agency of Canada, National Collaborating Centre for Indigenous Health and Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). Social Determinants of Health: The Canadian Facts. Oshawa: Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management.

All the determinants of health are important in determining a person's health, as well as their ability to maintain or regain health should they get sick. These determinants do not stand alone; indeed, they are connected, and one is often necessary for another to be in place. Here are a few examples for illustration.

Housing is an important determinant of health. A lack of housing has negative impacts on health and well-being directly, through the lack of protection that shelter provides, as well as indirectly, through stress and shame, the inability to secure access to a phone, difficulty getting and keeping a job, difficulty accessing and completing education, barriers to access healthy foods, difficulty accessing health care, and taking medication, and in many other ways. B.C. is currently experiencing a housing crisis, which is making it difficult or impossible for everyone except the very wealthy to access appropriate housing that meets their needs and pushing many into houselessness. It's not difficult to imagine why someone who's struggling with mental and physical health problems as a result, or worsened by, houselessness may need to use substances to feel better – and if we want to prevent harms from that substance use, housing is a necessary piece of the solution.

Access to health services was an issue seen among those in the 2021–2022 chart review.

Our physical environments and health systems can be difficult to access without things like reliable and affordable transportation and telephone access. Not only are transportation and access to phone essential elements of the access to health services determinant, but they are also elements of employment, physical spaces, social connection and accessibility.

This is seen frequently by IH staff:

> **"Many clients are actively requesting electronic communication with MHSU. A lot have no vehicle…They want to attend groups but can't make it there, same with counsellor visits and rehabilitation services. There are virtual groups that are available, but most are in person again. On top of that there's no list of what we offer for clients to choose from, so even though a virtual service is offered, clients don't know about it."**

Discrimination in all settings, but especially in health-care settings, impacts both the care received as well as health outcomes, a sentiment that both peers and clients experience:

> **"The labelling and stigma made me feel less than human."**

In June 2020, the B.C. Minister of Health initiated a review of Aboriginal-specific racism in the provincial health-care system. The investigation found extensive examples of racism and discrimination against Aboriginal patients and resulted in the In Plain Sight (IPS) Report, with a full report published in November 2020 and a data report published in February 2021 (6). While IH is committed to acting on these recommendations, it is a work in progress which will be monitored and reported in semi-annual updates (10).

Addressing the determinants of health is challenging, multi-sectoral work. Some of these determinants are the responsibility of the health system, such as equitable access to health services. Some of these are the responsibility of municipal, provincial and federal governments. Some of these are everyone's responsibility, such as doing the work to be anti-racist, eliminating discrimination and supporting one another.

IH's Healthy Communities Healthy Families team works to improve the determinants of health in various ways:

Our teams operate by building partnerships, working from an equity and cultural humility lens, building capacity, sharing health evidence, tools and resources, and recognizing community best practices.

- Our Healthy Community Development team works with Indigenous communities, municipalities, regional districts and other partners to support the creation of healthy community planning, policy and actions that address social and health inequities.
- Our Healthy Eating and Food Security team brings together community partners to build capacity and facilitate knowledge exchange.
- Our Healthy Start team supports pregnant individuals and families to build knowledge, skills and confidence, and access health and social supports.
- Our Healthy Schools team builds capacity in the school sector to create healthier school environments that support students' physical, social and mental well-being.
- Our injury prevention lead works with provincial and local partners to change population level policies and practices that will prevent severe injuries and promote safety.

Primary prevention: Risk factor prevention

Primary prevention is addressing the factors that we know lead to, or are associated with, the condition.

The upstream analogy for primary prevention would be to address the risk factors for drowning: not being able to swim, or swimming in unsafe areas. If we equip people with knowledge, skills, safe equipment and safe access, drowning can be prevented. Here we can see youths with safe access to a calm area in the river.

Figure 8. Image of primary prevention analogy – youths swimming in calm water

Source: https://www.flickr.com/photos/russellmcneil/27747007474

When it comes to substance use or use disorder, there are many risk factors, including family environment, mental health and trauma, and personalities and coping behaviours (11)

In B.C., the demographic who we see dying most often from substance poisoning are men who work in the trades who use alone at home (12; 2). Therefore, working in trades is a risk factor for dying from substance poisoning. Addressing this risk factor might look like: reforming construction company policies to support treatment for substance use disorder or pain; making mental health services specifically targeting tradespeople available and accessible; the Tailgate Toolkit, an innovative program aimed at increasing access to harm reduction services and ideas for those working in the construction industry (13).

Addressing risk factors can also look like a family doctor or a qualified pain management practitioner working with their patient to ensure that their pain is under control. It could look like a cultural support worker or navigator supporting someone's access to cultural supports, such as connecting with an Indigenous Elder or engaging in a cultural ceremony.

It could look like a social worker or mental health worker connecting someone to mental health supports. It could be having healthy coping behaviour training available through schools.

One example of primary prevention is the Iceland prevention model (14). It's a program that supports youth to lead healthy lives and not need to use substances because their life is fun, they have plenty to do, and they are supported by the adults around them.

The risk factors for youth that are addressed are boredom, stress, access to substances, and lack of support and supervision.

The intervention is based on two key elements: 1. "Parental Agreements" that prompt conversations at school-parental meetings and family decisions around curfew, substance use, etc.; 2. Each youth is entitled to a municipal coupon that subsidizes the recreational activity of the youth's choice (sports, music, art, etc.).

In the 10 years following implementation of the Iceland prevention model, youth alcohol intoxication decreased from 42 per cent to five per cent, daily cigarette smoking dropped from 23 per cent to three per cent, and cannabis use dropped from 17 per cent to five per cent.

One example of an evidence-based, targeted primary prevention program IH has supported is PreVenture. This school-based program promotes mental health and reduces the risk of substance use for youth in grades seven and eight.

PreVenture helps high-risk students learn useful coping skills, set long-term goals and channel their personality traits towards achieving those goals. Since 2019, IH has supported seven school districts in offering the PreVenture program and is securing resources to expand the program to all interested public school districts, as well as First Nations and independent schools.

Another important primary prevention intervention for substance use is providing access to regulated alternatives to the illicit market. In our analogy here, regulated alternatives would be equivalent to providing a safe place to swim, without underwater hazards or rip currents – the risk factor being the poisoned supply. A public health approach to regulation of substances is a spectrum of interventions. The Government of B.C. has identified and started implementing a medical prescribed model for some substances, which means offering a wider variety of medication options to people with a diagnosed substance use disorder. This approach is beneficial for this specific population, but does not change the risk for people who cannot access that program.

A public health approach to regulation of substances is the way we minimize the harms from legal substances, such as cannabis, alcohol, and tobacco. For example, we have labelling requirements so that people know what is contained when they buy one of those substances. For example, instead of only choosing between suboxone or methadone as prescribed opioid agonist therapy (OAT), people with opioid use disorder may also be prescribed medications such as hydromorphone, Kadian, fentanyl patches or fentanyl powder, which may more effectively meet their needs. The medical model has many limitations. Primarily, there is a lack of available prescribers who are comfortable offering what they perceive as higher risk options, and these options are available only to those with a diagnosed substance use disorder.

We know people use drugs for a variety of reasons. If we want to replace the unregulated substance market, a wider variety of approaches will be required to provide regulated alternatives to the illicit market to those who need it in the communities where they live. This could look like a public health model that makes regulated substances available to people within a framework of regulations and safeguards such as a compassion club (15).

Secondary Prevention: Detecting and addressing underlying conditions early before they manifest

Secondary prevention is when we are detecting and addressing the problem as early as possible to mitigate the harms.

The upstream analogy for secondary prevention is having a lifeguard save someone who may be struggling to swim before they drown.

Figure 9. Image of secondary prevention analogy – lifeguards watching for swimmers

The classic example of secondary prevention is screening: testing for conditions before they are symptomatic. When we apply this to substance use, it could look like school-based screening for mental health problems during childhood or adolescence, or someone feeling comfortable enough with a family doctor to talk about problematic substance use, and accessing resources before they develop a substance use disorder.

Some prevention strategies may require access to health-care providers. Clients shared issues that may exist with accessing these services:

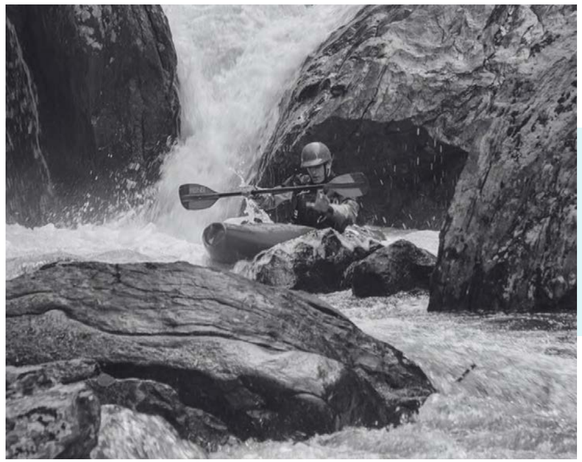
"The wait time to get a counsellor is so long I might relapse before I get one. What do we do in the meantime?"

In 2022, a new billable personal health risk assessment was made available for physicians in B.C. which includes identifying substance use risk (16). People with identified risk factors can call 310-MHSU (6478) to access IH Mental Health and Substance Use support directly.

"Doctors can be intimidating. They decide on your treatment and meds without your input."

Tertiary prevention: Preventing disease progression, death and other severe outcomes

Tertiary prevention is preventing harm and progression once a health problem has developed. Here we've separated it into two types: preventing disease progression, as well as preventing death and harms from poisoning or overdose.



The upstream analogy here is that the person is already in the whitewater rapids. If they have the right tools and skills, they are more likely to enjoy their life and less likely to drown despite being in the rapids.

Figure 10. Image of preventing disease progression analogy – a whitewater kayaker navigating some tricky rapids

Source: https://pixabay.com/photos/whitewater-kayaking-kayak-river-3402204/

Preventing disease progression

In the context of substance use, preventing harm and progression once a health problem has developed would be to provide treatment to someone who has a substance use disorder. For example, the primary goal of opioid agonist therapy (OAT) is to stabilize a person with physical dependence associated with opioid use disorder, and to improve overall functioning and quality of life.

OAT should be combined with wrap-around and psychosocial interventions, such as addressing their determinants of health, as well as targeted supports like counselling and/or support groups, to try and address the underlying causes of their substance use disorder.

For individuals with an opioid use disorder, OAT has been shown to be effective in reducing the need to access illicit substances, which then reduces the risk of substance poisoning and incarceration, and improves overall quality of life.

That said, some people may experience barriers to treatment and find other ways to cope that have their own challenges. For example, some workplaces like the trades specifically prohibit this type of medication, which decreases the likelihood that people who work in the trades can or will access treatment for substance use disorder.

IH is working hard to expand access to OAT, including partnership with First Nations Health Authority to support First Nations communities to explore options for OAT clinics directly in their communities and help mitigate barriers such as transportation and hesitancy to access IH services. You can see clinics and providers here.

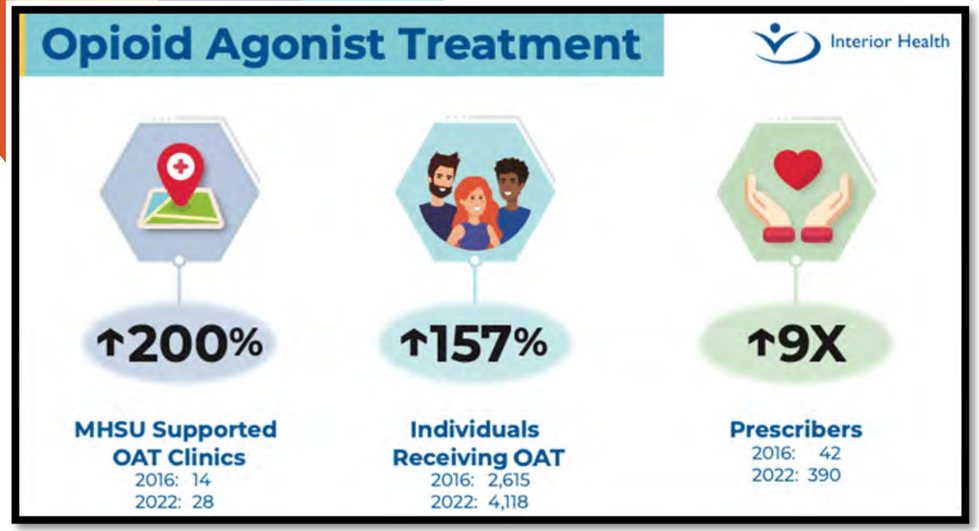


Figure 11. Increase in access to OAT in Interior Health 2016–2022

Source: http://www.bccdc.ca/health-professionals/data-reports/substance-use-harm-reduction-dashboard

Preventing death and other adverse consequences from overdose or poisoning

Emergency interventions are essential services to those who are in danger. Preventing death or injury from substance poisoning could look like helping someone who has stopped breathing from opioid poisoning. Anyone who uses unregulated substances, even for the first time, may need this lifesaving intervention, regardless of where they might fall along the substance use spectrum. In the context of substance use, rescue breathing and naloxone are life-saving interventions to prevent death from opioid poisoning. Anyone can access naloxone and learn how to save lives from opioid poisoning (see the BC Centre for Disease Control's Toward the Heart harm reduction services). Additionally, First Nations individuals can access nasal naloxone at any pharmacy through their non-insured health benefits.

Tertiary prevention for the harms from drowning include search and rescue, first aid, rescue breathing and CPR. These interventions for the consequences of drowning (e.g., lack of oxygen and the tissue damage as a result) are lifesaving for people who have drowned or are drowning.

Figure 12. Image of preventing death or consequences from poisoning analogy – large waterfall

Source: https://www.wallpaperflare.com/dawson-falls-wells-gray-provincial-park-british-columbia-canada-wallpaper-wvtgs

Harm reduction: Prevention through respect, dignity and compassion

Harm reduction is an approach to facilitate prevention through dignity, justice and human rights. Harm reduction policies, programs and practices apply across all levels of prevention.

Using our upstream analogy, harm reduction would be the lifeguard. Lifeguards can put signs up to indicate where it's safe to swim, help people who are struggling to swim, and rescue people who have started drowning. Lifeguards don't judge people for wanting to swim but are responsible for providing appropriate supports when needed.

Figure 13. Image for harm reduction analogy – a lifeguard sitting in a tower

Key features of harm reduction are respect and dignity. Harm reduction takes a compassionate and understanding approach of the upstream factors and aims to keep people as safe as possible while respecting their human rights and dignity. An IH substance use client emphasizes the difficultly in accessing services when not treated with respect and dignity:

"It's too difficult to access drug testing. I tried to have mine tested and was treated like a worthless f'ing junkie."

Harm reduction as **primordial prevention** looks like reducing stigma and discrimination in all settings, including health care. IH recently released a health authority-wide harm reduction policy. The goal of this policy is to help all IH staff understand how to address discrimination in their work and provide non-judgemental care as best practices.

Anti-racism and Aboriginal Cultural Safety & Humility policies are also relevant in the context of intergenerational trauma affecting Aboriginal Peoples. IH's cultural safety and humility training is being updated to specifically address Indigenous anti-racism.

Harm reduction as **primary prevention** looks like connections to counselling, group therapy and/or cultural supports.

Harm reduction as **secondary prevention** looks like undoing stigma by normalizing the discussion of substance use so people are more comfortable disclosing their use, getting their drugs checked and discussing where they fall on the spectrum of substance use.

Harm reduction as **tertiary prevention** looks like OAT clinics that support people who relapse to adjust their dose or their medication to better suit their needs, and peers running episodic overdose prevention sites (eOPS) and reversing an overdose with naloxone.

Recommendations

The purpose of this report is to dig deeper into our understanding of the unregulated substance poisoning crisis. By talking to people with lived or living experiences, and learning from the medical charts of those who passed, we can better understand what factors are important in their experiences, and the opportunities we have to support them better and keep them alive.

We then present the various levels of prevention to understand all the different ways we can prevent the need for substance use, how to strengthen our support for people who are at risk, and how the various interventions we need to implement in this public health emergency fit together along the 'stream.'

RECOMMENDATIONS FOR EVERYONE

1. Think about the perspectives of people who have lived experiences presented in this report. Reflect on how what was shared compares to, or contrasts with, perspectives based on stigma and stereotypes. Commit to anti-stigma and anti-racism work within yourself, your family, your community and your workplace.

RECOMMENDATIONS FOR INTERIOR HEALTH

1. Take deliberate action to counteract stigma in health-care settings.
    a. Involve people with lived experience in a meaningful way at all levels of decision making.
    b. Implement the IH Harm Reduction policy and educate all staff across the health authority to ensure that someone's quality and access to health care is not compromised by their past and/or current substance use.
    c. Develop and implement a Clinical Practice Standard for Substance Use in Acute Care to educate and equip staff on best practices to support people who use substances who are in care. Staff need to have the knowledge, ability, comfort, and confidence to care plan with each patient, work with addictions medicine, use prescribed alternatives wherever possible, and then document safety care plans if the patient needs to leave the hospital to use their personal substances out of necessity.
2. Design next steps for the toxic drug crisis response with First Nations and Métis partners, recognizing the commitment and engagement required for Indigenous-led work, including co-development and implementation of trauma-informed, culturally appropriate and safe, targeted healing and treatment services for Indigenous clients.
3. Improve care for people at risk of dying from unregulated substance poisoning. Develop, disseminate and implement recommendations from the chart review project. The data presented here from the chart review is preliminary; more work needs to be done to understand which factors may be useful for screening, what type of interventions may improve health services for people who use substances, and prevent deaths from poisoned substances.
4. Strengthen IH's approach to the unregulated substance poisoning crisis with a refreshed, comprehensive plan.

RECOMMENDATIONS FOR BC GOVERNMENT

1. Increase focus on upstream prevention, particularly the determinants of health.
    a. Housing is a particularly urgent need in B.C.
    b. Transportation was commonly cited as a barrier to services, and is especially problematic in and between rural areas.
2. Implement the recommendations from the BC Coroners Service Death Review Panel report:
    a. regulated alternatives to the illicit market,
    b. a coordinated, goal-driven provincial strategy, and
    c. a comprehensive evidence-based continuum of substance use care.

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Appendix A. Spectrum of Prevention

Upstream ←			→ Downstream	
Primordial Prevention	Primary Prevention	Secondary Prevention	Tertiary Prevention	
Addressing the determinants of health	Risk factor prevention	Detecting and addressing underlying conditions early before they manifest	Preventing disease progress	Preventing death and other severe outcomes
Healthy public policy, planning and practices Community and partner capacity building Supporting healthy babies, moms and families Creating healthier school environments Reducing stigma and discrimination	PreVenture Regulated alternatives to the illicit market Pain management Accessible athletic and art programs for all Counselling and/or group therapy Healthy coping behaviour training at schools	Billable personal health risk assessment School-based screening Primary care screening Normalizing discussions of substance use Drug checking	OAT clinics	Naloxone Rescue breathing Episodic overdose prevention sites led by peers
Harm reduction approaches span across all levels.				

Summary of actions at each of level of the prevention continuum.

These preventive interventions are integral to a comprehensive system of programs and partnerships that need to work together at every level to end the substance use poisoning crisis. The population health approach complements health care by addressing the underlying determinants of health and shifting investments upstream.