The Overdose Crisis

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Authors

Position Paper Chair: Winnie Fu, University of British Columbia, Class of 2024

Introduction and Background
Committee Chair: Ishita Aggarwal, Queen's University, Class of 2023
Kathy Zhang, Western University, Class of 2024
Jennifer Glassford, Northern Ontario School of Medicine, Class of 2022
Mirna Gerges, Dalhousie University, Class of 2025

Decriminalization
Committee Chair: Claudia Wakulchyk, University of Alberta, Class of 2024
Jessica Jun, University of British Columbia, Class of 2024
Winnie Fu, University of British Columbia, Class of 2024

Safer Supply
Committee Chair: Rachel Fung, University of Calgary, Class of 2023
Ella Zelter, University of McGill, Class of 2022
Grace Zhu, University of Ottawa, Class of 2022
Celine Prell, University of McGill, Class of 2023
Yousef Shahin, University of British Columbia, Class of 2024
Jessica Li, University of British Columbia, Class of 2022

Federal Standardization
Committee Chairs: Davy Lau, University of British Columbia, Class of 2024 and Ethan Candler, University of Alberta, Class of 2024
Smriti Juriasingani, University of Calgary 2024
Sera Whitelaw, University of McGill, Class of 2025
Yuxuan Jiang, McMaster University, Class of 2024

Reviewers
Annie Foreman-Mackey, University of British Columbia, Class of 2024
Ishmam Bhuiyan, University of British Columbia, Class of 2025
Jason Speidel, University of British Columbia, Class of 2023

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The Overdose Crisis

April 2022
POSITION PAPER
Summary

The overdose crisis has accelerated in recent years, with an alarming rise in mortality compounded by the COVID-19 pandemic. The main objectives of this position paper are to recommend a federal approach that confronts the systemic structures that underlie this crisis, including criminalization of drug use, barriers to harm-reduction services, and disparate responses to the crisis across Canada.
This paper recommends decriminalization of simple possession of all controlled substances to mitigate the harms caused by punitive policies, the development of a safe-supply framework to ensure low-barrier access to evidence-based services and implementation of minimum standards across Canada to enforce equitable access for all.

RECOMMENDATIONS

Recommendation 1: The federal government should ensure national decriminalization of simple possession of all controlled substances

Recommendation 2: The federal government should implement a comprehensive, low-barrier safer supply framework

Recommendation 3: The federal government should implement minimum standards to receive federal funding from the Mental Health Block Transfer

SUPPORTING EVIDENCE & RATIONALE

Supporting evidence for Recommendation 1: Drug prohibition and criminalization have been ineffective in reducing the use of illicit drugs, impede harm reduction service development and access, reinforce discrimination towards people who use substances, and fuel the illegal drug market.

Supporting evidence for Recommendation 2: Comprehensive and universally accessible safer supply must be a core component of harm reduction-based frameworks, with a dispensing model that considers the individual preferences, habits, and geographic distributions of people who use drugs (PWUD).

Supporting evidence for Recommendation 3: Using the federal mental health block transfer to fund overdose surveillance, safer supply, and harm reduction interventions will ensure a uniform approach to health service access across Canada

INTRODUCTION & BACKGROUND

A Growing Crisis: Driven by an increasingly toxic, unregulated drug supply, the overdose crisis in Canada has brought about more than 20 years of drug-related fatalities and harm. This public health crisis is devastating the lives of people in Canada, with a disproportionate impact on poor and racialized PWUD.

Canadian Trends: In 2020, the overdose crisis claimed the lives of 6,306 people in Canada.[1] The number and rate of deaths have continued to increase in Canada, with 5,368 apparent opioid toxicity deaths recorded between January and September 2021. More than half of accidental opioid toxicity deaths in this time period involved stimulants like amphetamine and cocaine. Fentanyl and fentanyl analogues continue to be major drivers of the crisis,[1] as well as the emergence of novel psychoactive substances.[2]

Provincial Differences: While the number of substance-related deaths in Canada has continued to rise, it is important to note that the effects have been felt disproportionately across the country. For example, between January and September 2021, 88% of all apparent opioid toxicity deaths occurred in British Columbia, Alberta, or Ontario. Furthermore, the crude rate per 100,000 population of opioid-toxicity deaths between January and September 2021 in the Yukon was 46.5, followed by Alberta at 33 and British Columbia at 31.3. Within the same time frame, crude rates of opioid toxicity deaths in the Atlantic provinces were substantially lower compared to other provinces.[1]

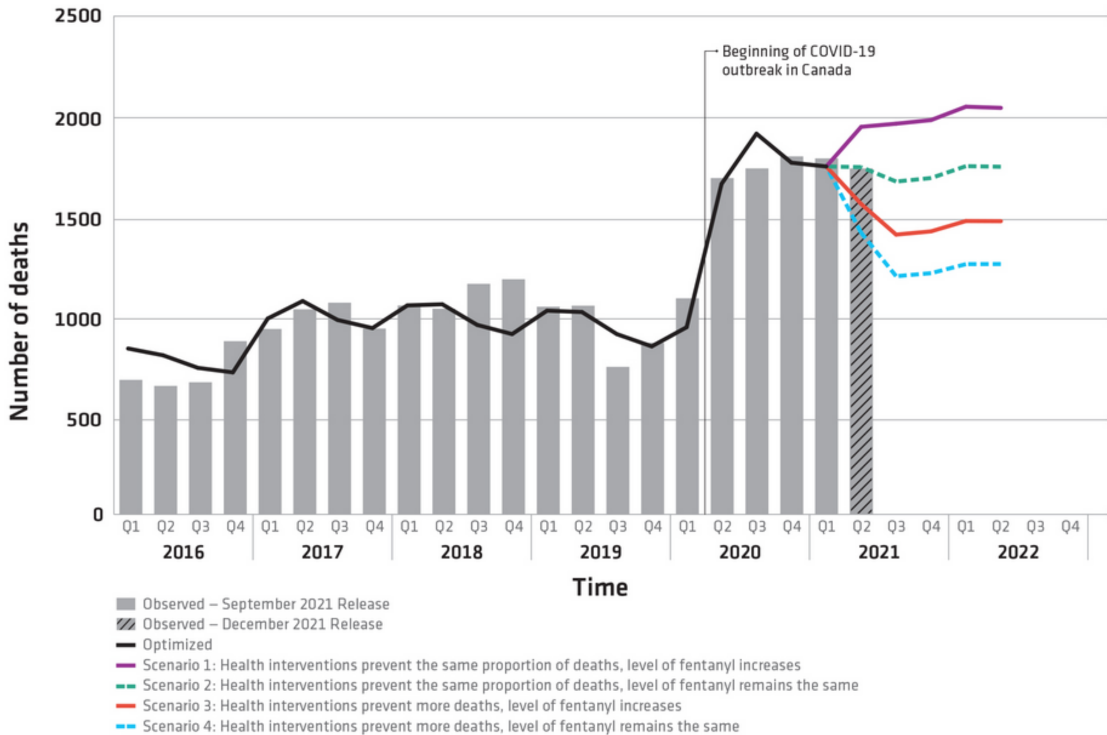
Complex Factors: The overdose crisis has resulted from a number of complex and interrelated factors. The current prohibition-based legal landscape around drug use has contributed to discrimination and stigma against PWUD. This has also led to a toxic drug market. The third wave of the overdose epidemic has largely been driven by fentanyl contamination in the illicit drug supply. Furthermore, evidence-based, harm reduction services like opioid agonist therapies (OAT), overdose prevention sites (OPS), and safe consumption sites (SCS) continue to be complicated by access issues. Stigma, racism, and the current legislative landscape in Canada create barriers that prevent PWUD from seeking and receiving the care and support they need.[3]

COVID-19

The COVID-19 pandemic has disproportionately impacted PWUD. Canada observed a significant increase in overdose-related deaths that coincided with the beginning of the pandemic. Every province that reported opioid toxicity deaths to the Public Health Agency of Canada (PHAC), saw a rise in death rates from 2019 to 2020, with the exception of Nova Scotia.[1]

Based on PHAC projections of opioid-related deaths, existing levels of health interventions are not sufficient to bring about a drop in fatalities (Figure 1).[4]

Figure 1. Observed and projected opioid-related deaths, Canada, January 2016 to June 2022[4]



Use of health services for substance-related incidents also changed dramatically during the pandemic. Hospitalizations due to opioid poisoning increased 20% from 2019 to 2020 and another 11% from 2020 to 2021. Emergency Medical Services (EMS) responses to opioid-related overdoses increased 63% from 2019 to 2020 and another 31% from 2020 to 2021.[1]

A qualitative investigation by the Canadian Centre on Substance Use and Addiction (CCSA) demonstrated how public health responses in the context of the COVID-19 pandemic, such as physical distancing and social isolation, negatively impacted communities and PWUD. Access to healthcare services were disrupted, with harm reduction service providers canceling services and struggling with lack of resources such as PPE, as well as the transition to virtual support meetings creating barriers for people without digital devices or stable internet.[5] Physical distancing was challenging for those without stable housing or reliable employment (which became more precarious during the pandemic). The pandemic and associated isolation also created additional stressors to mental health. More PWUD reported consuming substances alone without someone close by to respond in the event of an overdose. Additionally, the pandemic coincided with increased toxicity in the drug supply.[1] Finally, PWUD face higher risk of complications from COVID-19 due to high rates of comorbidities and pre-existing health issues.[6]

The limited ability to physically distance and the risks of COVID-19 infection disproportionately affect marginalized populations,[7] shaped by existing inequitable treatment and social determinants of health, including gender, sexual orientation, race and ethnicity, disability, socioeconomic status, Indigeneity, homelessness, incarceration, and occupation. The discriminatory treatment of certain groups compounded with pandemic challenges makes combating the overdose crisis even more crucial. As one informant from the CCSA interviews aptly described, "[...] It's a pandemic on top of an epidemic."[5]

Policies/Interventions

It is important to note that there is no single intervention that will provide a "silver bullet" solution to the challenges associated with the overdose crisis in Canada. However, front-line workers and PWUDs have repeatedly emphasized harm reduction as a core principle in the approach to the overdose crisis.

A myriad of evidence-based harm reduction services has been implemented across the country.[8] These strategies include the use of naloxone, which temporarily reverses the effects of overdose. Naloxone is available for free and does not require a prescription across any province.[9,10] Other interventions include SCS, which provide safe spaces for individuals to consume substances, with medical personnel on site, and access to sterile needles and naloxone kits.[11] The federal Minister of Health exempts these sites from legal prosecution under section 56.1 of the Controlled Drugs and Substances Act. Additionally, community-led interventions have presented a viable alternative to government-run services. These include overdose prevention sites (OPS), which include similar harm reduction interventions as those found in SCS but are lower-threshold and are often run by peer workers.[11] OPS operate pursuant to provincial Ministerial Orders and/or temporary class exemptions from the federal Minister of Health. Compassionate distribution programs such as heroin compassion clubs propose a cooperative model that is member-driven and cost-effective.[12] They are inspired by cannabis compassion clubs developed at the height of the AIDS epidemic during the era of marijuana prohibition.[13] Treatment-based models such as OAT include provision of prescription opioids that are longer-lasting and can help mitigate the effects of withdrawal, thereby promoting recovery from substance dependence. Additionally, addiction treatment resources, development of new integrative care models, and training of first responders and healthcare providers can provide further supports in a recovery-oriented spectrum of care.[14]

There is an increased demand for coupling standard harm reduction practices with systemic interventions that address the stigma and discrimination that creates barriers to access, such as addressing housing instability[14,15] and removing legislation that criminalizes PWUDs.[16]

Stakeholder Perspectives

Various stakeholders across Canada were consulted in informing the recommendations of this position paper, including physicians, government personnel, community organizations, and those with lived experience of substance use. There was a shared sentiment of frustration at the state of the current overdose crisis: "Being a drug user these days is a death sentence," said one individual, summarizing the sense of despair over the lives that have been and will continue to be lost over the course of this public health emergency if further action is not taken.

Stakeholders identified some common exacerbating factors of the overdose crisis, including the increasing toxicity of the drug supply, ongoing stigma towards PWUD, and the additional impact of the COVID-19 pandemic. They also pointed to socioeconomic factors, such as lack of accessible employment and precarious housing as fueling the crisis.

Although experiences vary across the provinces, stakeholders from coast to coast outlined similar suggestions about how Federal, Provincial, and Municipal governments should respond to the overdose crisis. In particular, stakeholders expressed concern about the lack of equitable access to OAT, SCS, treatment facilities, and other harm reduction and treatment services across the country.

Implementation of these evidence-based strategies has largely fallen to PWUD, as well as provincial and municipal levels of government, generating disparate regional responses to this crisis. These obstacles serve to perpetuate stigma surrounding drug use and contribute to death, particularly in regions where resources are limited by the political leadership's response to the crisis. To address this concern, stakeholders ultimately called on the federal government for a more coordinated approach to address the overdose crisis, including increased funding and improved accessibility to evidence-based care at the community level.

Stakeholders also identified safer supply and decriminalization as two critical strategies in mitigating stigma and future overdose deaths and acknowledged that coordinated federal action on the crisis at large is critical to scale-up these efforts.

Closing/Recommendations

Tackling this public health emergency requires commitment from a wide variety of stakeholders and implementation of novel prevention and care practices. This report describes three such strategies, including decriminalization of simple possession of controlled substances, federal standardization, and safer supply.

KEY PRINCIPLES

The CFMS endorses the following principles:

1) Harm reduction is a core component in addressing the overdose crisis.
2) The overdose crisis is a public health and discriminatory governance issue, not a criminal justice issue.
3) People with lived/living experience should have leadership roles and decision-making capacity in policy decisions that affect their community.
4) Safer supply is evidence-based.
5) Appropriate, evidence-based healthcare should be accessible to all, regardless of geographic location and regional political ideology.

RECOMMENDATIONS

1. The Federal government should immediately implement national decriminalization of simple possession of all controlled substances. A federal decriminalization model should include:
    a. A repeal of section 4 of the CDSA, which prohibits the simple possession of controlled substances; this repeal must not be replaced with administrative penalties or medical sanctions related to simple possession;
    b. Ensure that PWUD have decision-making power and leadership roles in policy development related to decriminalization, including the ongoing evolution of if and how threshold quantities are determined;
    c. Any threshold quantity should not be fixed in federal law but evidence-based and contextual based on local drug use patterns, recognizing that these may evolve over time. Police should have no role in determining threshold quantities.

2. The Federal government should implement a comprehensive, low-barrier safer supply framework, which should include but not be limited to:
    a. Availability of and access to safe substances of known quality and quantity that match those sought by PWUD (or a close alternative) across all 10 provinces and 3 territories, with federally funded safer supply programs adopted by all currently active SCS and community addiction programs where applicable;
    b. A de-medicalized service model that expands and diversifies the provision of safer supply with respect to dispensing sites, dispensing conditions (including carries) and operational hours. Expansion should be dictated by PWUD in order to allow for autonomy in drug administration and sustainable provision of take home doses;
    c. Development of safer supply programs made with the engagement and collaboration of PWUD, with sufficiently comprehensive federally funded drug coverage to account for substance preferences as they vary by demographics and geographical area.
3. The Federal government should implement minimum standards to receive federal funding from the Mental Health Block Transfer:
    a. Use the Liberals' proposed $4.5 billion federal mental health block transfer to fund overdose surveillance, safer supply, and harm reduction interventions, ensuring minimum standards are met by each province/territory in order to receive the funding.
    b. Overdose and substance-related harms and outcomes should be surveilled across every community so that resource allocation and intervention standards are proportional to population need, both inter- and intra-provincially.
    c. Maintain harm reduction as a core principle in negotiations with provinces and in the activities of the Mental Health and Addictions Ministry.

Recommendation 1: National decriminalization of simple possession of all controlled substances

Concern 1: Applications for decriminalization are currently submitted by region/jurisdiction, effectively premising drug policy and related health supports on lines of resources, capacity, and political will of non-federal levels of governments. Application-based decriminalization also perpetuates social and health inequities and disproportionately affects communities that are already at higher risk and have limited access to health services.
Concern 2: Criminalization creates barriers to accessing and developing harm reduction services, reinforces stigma, discrimination, and incarceration of PWUD, and fuels a toxic unregulated drug market. These harms further disproportionately affect already marginalized communities.
Concern 3: PWUD are not meaningfully engaged in decision-making around decriminalization.
Concern 4: Deterrence-based decriminalization that maintains conditions and sanctions continue to stigmatize and make it difficult for PWUDs to seek meaningful support.
Recommendation 1: A repeal of section 4 of the CDSA, which prohibits the simple possession of controlled substances; this repeal must not be replaced with administrative penalties or medical sanctions related to simple possession
Recommendation 2: Ensure that PWUD have decision-making power and leadership roles in policy development related to decriminalization, including the ongoing evolution of if and how threshold quantities are determined
Recommendation 3: Any threshold quantity should not be fixed in federal law but evidence-based and contextual based on local drug use patterns, recognizing that these may evolve over time. Police should have no role in determining threshold quantities.

Supporting Evidence & Rationale

Full decriminalization means that all criminalizing legislation, penalization, and sanctioning related to possession of all controlled substances must be removed, given that fentanyl and other powerful opioids have been found in samples of depressants and stimulants alike.[17] While decriminalization engages criminal provisions under the *Controlled Drugs and Substances Act*, it has been repeatedly asserted by politicians, medical experts, and academics that substance use and addiction are public health issues rather than criminal justice issues.[18] Canada's healthcare system centers around the principles of universality and accessibility[19] and a national decriminalization strategy will ensure that all people have equal access to a full spectrum of appropriate supports without stigmatization, including harm reduction, treatment, and recovery programs. The overdose response in Canada must be evidence-based, and recommendations for a national strategy should include intentional mechanisms for implementation and accountability, regardless of jurisdiction or region.

Discrimination and stigma have been perpetuated by a history of prohibition in Canada, and the *Charter* and human rights of PWUD have often been undermined, especially when acknowledging the historical, intergenerational, and persistent harms faced by those groups disproportionately impacted, including, but not limited to, underhoused populations and racialized communities.[20] A public health approach provides a framework for responding to the overdose crisis while considering the complex factors that lead to substance use, addiction, and ongoing stigmatization. A wide range of behavioural, socioeconomic, and cultural factors are important determinants of prevention, treatment, and recovery. To address the harms faced disproportionately by marginalized and traditionally underserved populations, a guiding principle of national decriminalization must include protecting the rights and freedoms of all PWUD, and ensuring that those directly impacted are empowered with decision-making capacity at every step of the process.[21]

The role and enforcement of threshold quantities as part of a full decriminalization strategy should be carefully assessed. PWUD should remain at the forefront of the movement towards decriminalization, as the implementation of legal threshold quantities has been highlighted by peer advocacy groups and other experts as a potentially dangerous limitation of current decriminalization efforts in Canada and internationally.[22,23] Current models of decriminalization that fail to address these concerns about too-low threshold quantities reflects how peer advocates are often tokenized in the decision-making process, resulting in policies that leave the most marginalized PWUD vulnerable to harm.

Imposing too-low threshold quantities empowers law enforcement to make decisions that continue to criminalize PWUD facing additional barriers such as limited access to suppliers and limited mobility, as well as leaving PWUD vulnerable to the systemic racism and discrimination inherent to interactions with law enforcement. In addition to perpetuating stigma, the threat of police engagement will continue to deter marginalized PWUD from safely accessing health and harm reduction services, which is in conflict with the intended outcomes of a decriminalization strategy.[23] An effective and equitable decriminalization strategy will not rely on arbitrary police discretion to enforce these design features. Rather, PWUD should be consulted in quantity determination to ensure that threshold quantities are appropriately high to mitigate the risk of harassment and/or criminalization of PWUD for simple possession, and it should be recognized that appropriate threshold quantities may vary based on local drug use patterns as well as evolve over time (e.g., may be increased during a pandemic to mitigate risk from exposures)[22]. Furthermore, it should be recognized that this is an ongoing process that requires engagement with PWUD in each community where threshold quantities are imposed, and PWUD should

be engaged in legal decision-making surrounding enforcement of these policies to ensure that vulnerable members of the community are not being targeted or placed at risk.

There is no place for criminal justice in a public health crisis. In decriminalizing simple possession, we also underscore the fact that law enforcement should not be at the forefront of the overdose crisis and should not be the gatekeepers of healthcare services. This latter point must be considered if and when contemplating a mechanism for providing PWUD with referrals of any kind (i.e. to healthcare services, harm reduction supports, iOAT, etc).

The importance of full, and not partial decriminalization, must be emphasized. In 2001, Portugal removed criminal sanctions related to simple possession of drugs for personal use. While the country saw significant declines in HIV incidence, morbidity, and mortality, drug users did not see practical benefits to this legislation, as the criminal model transitioned to a semi-compulsory, medicalized model that maintained the practice of drug confiscations and diverted users to dissuasion committees, which resulted in fines and/or other administrative penalties. This continues to disproportionately affect poor and racialized communities.[24] Decriminalization cannot be attached to administrative penalties or involuntary healthcare interventions. Punitive measures and mandatory rehabilitation continue to fuel stigma by forcing interventions and removing autonomy. Transitioning from an oppressive criminal justice approach towards a similarly oppressive health-based system will continue to create barriers to access, fuel stigma, encourage harassment, and continue to financially burden society.[24] We cannot expect meaningful trust or engagement of healthcare services if the principle of individual patient autonomy is not respected in the process.

d. Availability of and access to safe substances of known quality and quantity that match those sought by PWUD (or a close alternative) across all 10 provinces and 3 territories, with federally funded safer supply programs adopted by all currently active SCS and community addiction programs where applicable;
e. A demedicalized service model that expands and diversifies the provision of safer supply with respect to dispensing sites, dispensing conditions (including carries) and operational hours. Expansion should be dictated by PWUD in order to allow for autonomy in drug administration and sustainable provision of take home doses;
f. Development of safer supply programs made with the engagement and collaboration of PWUD, with sufficiently comprehensive federally funded drug coverage to account for substance preferences as they vary by demographics and geographical area.

Recommendation 2: A Comprehensive, Low-Barrier Safer Supply Framework

Concern 1: Rising contamination and instability of the unregulated drug supply, compounded by COVID-related disruptions to supply chains, is complicating the overdose crisis.
Concern 2: Only a small subset of the at-risk population is able to access existing safer supply supports, with significant disparity in regional and interprovincial availability.
Concern 3: Safer supply is available primarily in medicalized environments, with multiple daily visits and the potential for re-traumatizing a medically-vulnerable population, which creates barriers for many PWUD.
Recommendation 1: Availability of and access to safe substances of known quality and quantity that match those sought by PWUD (or a close alternative) across all 10 provinces and 3 territories, with federally funded safer supply programs adopted by all currently active SCS and community addiction programs where applicable

Recommendation 2: A de-medicalized service model that expands and diversifies the provision of safer supply with respect to dispensing sites, dispensing conditions (including carries) and operational hours. Expansion should be dictated by PWUD in order to allow for autonomy in drug administration and sustainable provision of take home doses

Recommendation 3: Development of safer supply programs made with the engagement and collaboration of PWUD, with sufficiently comprehensive federally funded drug coverage to account for substance preferences as they vary by demographics and geographical area.

Supporting Evidence and Rationale:

The current and broadly accepted application of regulated alternatives to illicit substances is largely limited to OAT, a treatment-based approach used to manage opioid use disorder, often with the end-goal of abstinence.[25,26] While helpful for some individuals, the treatment-centered approach can prove prohibitive to some PWUD, reflected in treatment attrition, low medication adherence, and concurrent use of unregulated substances alongside OAT.[27] Safer supply, by contrast, is a harm reduction approach, intended to provide PWUD the desired effects of recreational drug use within a regulated framework, thereby avoiding the significant morbidity and mortality burden associated with consumption of unregulated illicit substances.[26,28] It is critical to acknowledge that not all PWUDs are amenable to or suitable for conventional treatment, and that we must incorporate harm reduction-based safer supply as a necessary alternative or adjunct to treatment-based OAT to effectively address the overdose epidemic.[29] We believe it is necessary to regard addiction not as a personal or moral failing, but rather as a health issue demanding comprehensive management.

With illicitly-manufactured fentanyl driving a significant and rapidly rising number of opioid-related deaths in Canada,[1,28,30] there is an increasing body of evidence supporting the use of safer supply as a fundamental component of our public health management strategy. A four-year safer supply program in Ontario revealed a 90% retention rate and zero fatal overdoses among participants[25] - a remarkable success amidst rising overdose deaths and the substantially lower success rate of OAT alone.[27] A recent project in Vancouver suggested that a hydromorphone tablet distribution program reduced overdose risk while also achieving a secondary benefit of addressing social inequities stemming from illicit drug use such as sleep and nutrition, as self-reported by program participants.[31] Similarly, a study assessing prescribed heroin as an adjunct to OAT revealed decreased incarceration rates, improved treatment retention, and possible reduction in mortality.[32] There remain, however, significant barriers to accessing safer supply, including geographical barriers, with only 29 federally funded sites in 5 provinces;[33,34] eligibility, with access limited strictly to those with the highest acuity and excluding the majority of those at risk of fatal overdose;[34,35] and access, as PWUD are currently limited to a medical prescriber model and restricted to limited doses and formulations.[26,34,36–38]

We believe that we are at a critical juncture in the overdose crisis. Overdose deaths are rising at an unacceptable rate, exacerbated by the COVID-19 pandemic, causing prolonged social service disruptions, widening social inequities, and disturbances to the already unstable illicit drug supply chain.[39,40] Safer supply interventions, while currently supported by the federal government, are largely inaccessible to the majority of the at-risk population, with significant intra- and inter-provincial disparities. We call for urgent expansion of safer supply programs as well as reduction of barriers to accessing safer supply. This includes, but is not limited to the allocation of political resources and funding to develop infrastructure that is available in all 10 provinces and 3 territories, and that

leverages currently available harm reduction programs; federally funded drug coverage for supply of safe substances; protocolized provision guidelines for all healthcare providers including physicians, pharmacists, and nurse practitioners (See Appendix A); engagement with PWUD to ensure comprehensive substance and dosing coverage across all ages, geographic areas, and ethnic identities; and de-medicalization with access independent of repeat visits to a provider and supported by programs such as take home doses and anonymous secure lockbox programs.

Recommendation 3: Implement minimum standards to receive federal funding from the Mental Health Block Transfer

Concern 1: The resources allocated to preventing overdoses and substance-related harms is fragmented and inconsistent across provinces and territories in Canada, meaning individuals in some locations cannot access the resources they would otherwise be able to in other jurisdictions.
Recommendation 1: Use the Liberals' proposed $4.5 billion federal mental health block transfer to fund overdose surveillance, safer supply, and harm reduction interventions, ensuring minimum standards are met by each province/territory in order to receive the funding.
Recommendation 2: Overdose and substance-related harms and outcomes should be surveilled across every community so that resource allocation and intervention standards are proportional to population need, both inter- and intra-provincially.
Recommendation 3: Maintain harm reduction as a core principle in negotiations with provinces and in the activities of the Mental Health and Addictions Ministry.

Supporting Evidence & Rationale

Canada's current response to the overdose crisis continues to be inequitable and insufficient to address the urgency of the public health emergency. Although the burden of substance use is high in Canada compared to other areas of healthcare, there is disproportionately less funding available to provide services for PWUD. In addition, the response to the overdose crisis is inconsistent across provinces. Harm reduction services are often more concentrated in urban areas and access is left to jurisdictional discretion, which can change depending on the political will of the region. Instead of being viewed as a public health emergency, the overdose crisis is continually politicized, criminalized, and ideologized, meaning that PWUD will not have access to resources otherwise available to them if they lived in another area of Canada. This level of fragmentation would not be acceptable in any other area of healthcare today. Therefore, the optimal solution would be to ensure that adequate funding is allocated specifically to address the overdose crisis, and that standardized criteria must be met to receive this funding.

The Liberal Party's proposed 5-year $4.5 billion federal mental health block transfer has the potential to satisfy both of these concerns.[41,42] This transfer is unique in that it would ensure that funds are used toward mental health specifically, while traditionally the federal government has transferred funds to provinces through the Canada Health Transfer (CHT), which would be used for healthcare in general, as decided by each province and territory.[43] This idea was conceived in the context of the COVID-19 pandemic, a time where the increased need for mental health supports was painfully evident, and having this dedicated funding would ensure prioritization of mental health.[42]

We recommend that proportionate resources from this transfer be allocated to the establishment and ongoing provision of services aimed at preventing overdoses and reducing morbidity among PWUD. We also recommend that certain minimum criteria be outlined by the Federal

government, based on the burden of disease of each region, that must be met by each province/territory in order for this funding to be received. There is precedence for this form of oversight in the Affordable Child Care for All Plan to increase standardization across provinces and territories. This approach can ensure adequate affordability, accessibility, and quality of childcare that each province must meet to receive funds.[44]

The minimum criteria for this mental health block transfer should include federal standards to address the overdose crisis in each province/territory, as well as each community's specific needs within each province. For instance, funds should be used to create accurate surveillance systems for overdose tracking and reporting, as well as for research into the following: the epidemiology of substance use disorders, the treatment of PWUD by the justice system, and the availability of harm reduction services, in both urban and rural communities.

Based on the data collected from this surveillance and research, funds should then be properly allocated to increase access to substance use and harm reduction services where they are needed most. Evidence-based interventions that have been associated with lower rates of overdose and other substance-related harms include: SCS, drug checking sites, naloxone kit distribution, clean needle distribution, and OAT.[45] It is imperative that all of these services are made available and have low-barriers to access in each province and territory, especially in localities where the burden of overdose is shown to be higher, while also targeting populations that are overrepresented in substance use morbidity and mortality, such as Indigenous groups.[46] Additionally, low-barrier services and basic anti-stigma standards should be implemented across the country as an essential component of minimum standards necessary to access the mental health block transfer funds. Prioritization of marginalized communities that historically and presently experience discrimination and medical violence in the context of health services is important to ensure equitable services, access, and health outcomes.

There are some barriers to this federal standardization approach. Some politicians, such as BC Minister of Health Adrian Dix, have voiced the belief that a mental health block transfer is unnecessary, and that they would continue to fund mental health through the Canada Health Transfer.[42] Furthermore, provinces may prefer not to have standards set by the federal government on how to spend funds so they can cater to their own jurisdictions.[42] Regardless of these varying opinions, setting minimum services standards for the mental health block transfer would ensure that more equitable standards of care for PWUD could be implemented across Canada, allowing for transparency and accountability from each province and territory. In addition, having dedicated mental health funding ensures mental health is prioritized. This is especially important considering Canada spends 7% of health expenditures on mental health — disproportionately less than other OECD countries.[42] Lastly, setting minimum federal standards is not in conflict either with provincial health jurisdiction or with the unique needs of individual provinces. By having the federal government require funds to be used for the creation of surveillance systems for overdoses and conducting a proper needs assessment in different communities, each province will be better equipped with the information necessary to tailor allocation of funds to effective regionally specific interventions to the overdose crisis.

Overall, we believe this mental health block transfer has the potential to bring a unified, consistent response to the overdose crisis that is affecting people in Canada in all provinces and territories, so that all PWUDs, regardless of where they live, will have access to life-saving resources and services.

Relation to Previous CFMS Papers

This paper modifies the stance outlined in the CFMS Position Paper: Criminal Justice Reform Related to Substance Use in unequivocally stating that criminal justice has no role to play in the overdose crisis, and full decriminalization must be implemented. We also emphasize the importance of a full, not partial, decriminalization model. We underline the importance of ensuring people with lived and living experience have leadership roles in decision-making around the terms of decriminalization.

This paper modifies the stance outlined in the CFMS Position Paper: Responding to Canada's Opioid Crisis in placing the burden of this crisis on inadequate public policy response, criminalization of a public health issue, and a patchwork response to this crisis across the country. We build on their stance to increase harm reduction services by proposing a unified, national response to the crisis rather than the current patchwork approach that allows provincial and municipal leadership to make decisions based on political ideology.

ADVOCACY PLAN & FOLLOW-UP STRATEGY

Immediate Follow-Up Plan

- Develop a communication plan with press releases/statements and media interviews as appropriate.
- A copy of the position paper to be emailed to the following:
    - Minister of Justice and Attorney General of Canada
        - With particular emphasis on the recommendation for removal of criminal sanctions for all controlled substances that meet criteria for simple possession
    - Minister of Health and Mental Health and Addictions, Chief Public Health Officer of Canada, Public Health Agency of Canada, Canadian Drugs and Substances Strategy, Institute of Neurosciences, Mental Health and Addiction
        - With particular emphasis on the recommendations for a comprehensive safer supply framework and utilizing the mental health block transfer to create a national standardized strategy to combatting the overdose crisis
    - Request a meeting with the above recipients to discuss the paper and next steps. Response should be requested within 2 months.
- Collaborate with medical regulatory bodies, including
        - Canadian Medical Association
        - Royal College of Physicians and Surgeons of Canada
        - National Association of Pharmacy Regulatory Authorities
        - The Canadian Council for Practical Nurse Regulators
        - Canadian Nurses Association
    - In doing so, we will partner alongside these regulatory bodies, asking for support and collaboration in our communication with government bodies
        - This could include issuing a statement acknowledging the importance of the issue and motivation behind our work, which may in turn encourage the federal government to respond to our follow ups

Long-Term Implementation Strategy

1 year goal & action plan:

- Continued collaboration with medical regulatory bodies

- A response will have been elicited from the above stakeholders

2-5 year goal & action plan:

- Continued tracking on the status of decriminalization, a comprehensive safer supply framework, and setting minimum standards across each province's response to the overdose crisis. Additional pressure on government stakeholders will be applied as needed.

CONCLUSION

The overdose crisis has accelerated in recent years, driven by inadequate public policy responses, the criminalization of drug use, inaccessible interventions, and a fragmented approach to solutions across the country. This public health crisis, which claimed 3,515 lives in Canada in the first six months of 2021,[1] can be addressed through sensible and humane policies that are outlined in this paper. The overdose crisis does not exist in isolation; as evidenced by the drastic increase in overdose deaths and EMS service use since 2020, the overdose crisis has been exacerbated by the COVID-19 pandemic. Eclipsed by the pandemic, the overdose crisis has been largely ignored in recent months, despite its increasing and alarming severity. The COVID-19 pandemic has impeded the ability of PWUD to access healthcare services and has aggravated existing inequities in our society. Given the ways in which these two health crises have interacted, as well as increasing drug toxicity and overdose-related deaths, it is imperative that we urgently decisively act to address the overdose on a national level.

The current approach to drug policy in Canada, which is characterized by the criminalization of drug use and the exclusion of PWUD from decision-making processes, has introduced barriers to accessing care, perpetuated stigma, and fueled an unregulated and unsafe drug supply. This paper recommends a complete national decriminalization strategy, which removes criminal sanctions, centers on the experiences and expertise of PWUD, and rejects the implementation of a medicalized model that would subject PWUD to dissuasion tactics. This paper also recommends the introduction of a low-barrier safer supply framework. Although safer supply programs currently exist, a small minority of PWUD have access to them, and current services are heavily medicalized. The provision of safer supply in every Canadian province, using a low-barrier model that is created with PWUD, would remove many of the barriers that currently deter the use of existing safer supply services. Finally, this paper contends that a core principle of a national response to the overdose crisis must be the implementation of federal minimum standards. A departure from the current fragmented approach to the overdose crisis, by implementing a mental health block transfer, would ensure that all provinces sufficiently fund harm reduction and safer supply interventions. This crisis transcends provincial boundaries, and therefore warrants a comprehensive and unified national response.

In order to meaningfully respond to the accelerating overdose crisis, we must mobilize a national response that is evidence-based, accessible, universal, and led by PWUD. The three recommendations outlined in this paper are important steps that can be taken to address this crisis that will meaningfully mitigate the overdose mortality.

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COMMUNITY RESOURCES

Organization	Website Link	Main contact person (if any)	Email address	Other information
Good2Talk	https://good2talk.ca/		1-866-925-5454	Ontario-based help line for 17-25 year olds
London InterCommunity Health Centre: Safer Opioid Supply Program	https://lihc.on.ca/programs/safer-opioid-supply-program/		General info contact: 519-660-0875 ex 1290	Other contact differs by site: https://lihc.on.ca/wp-content/uploads/2021/01/2020-SOS-General-Public-Information.pdf
Crosstown Clinic (Vancouver)	https://www.mvaec.ca/directory/directory-list/providence-crosstown-clinic		(604) 689-8803	
Direction 180 (Halifax)	https://direction180.ca		(902) 420-0566	
Ensemble Moncton	https://ensemblegm.ca/services/		(506) 859-9616	
Oasis Clinic - Sandy Hill Community Health Centre (Ottawa)	https://www.shchc.ca/programs/oasis	Robert Boyd - Oasis Program Director	613-569-3488 ext 2112 rboyd@sandyhillchc.on.ca	
Ottawa Inner City Health (OICH)	https://www.ottawainnercityhealth.ca/			
DUAL (Drug Users Advocacy League - Ottawa)	https://dualottawa.wordpress.com/			
Vancouver Area Network of Drug Users	https://vandureplace.wordpress.com		vandu@vandu.org	
DTES SRO Collaborative	https://srocollaborative.org			
Drug User Liberation Front	https://www.dulf.ca			

APPENDIX A

Although this paper has primarily focused on government-level action, a key barrier to access has been within the healthcare system, which severely lacks training in opioid agonist therapy. Studies across Canada have identified a clear need to educate physicians on the management of substance use disorder; this has been evident in primary and acute care settings.[47–52] To that end, we encourage the following actions be introduced to medical training:

1. Additional substance use disorder training is introduced to the curriculum at the undergraduate level. Specifically, this should include OAT prescription for opioid use disorder.
2. Expansion of residency and fellowship training in addiction medicine, including:
    a. A thorough review of current curricula across pertinent medical residency specialties (including but not limited to emergency medicine, family medicine, internal medicine, psychiatry, and public health and preventive medicine) to include comprehensive training in substance use disorder; and
3. Creation of residency training opportunities that focus on addiction medicine and expansion of current addiction fellowship training.
4. Development of robust training programs with continuing medical education (CME) or continuing professional development (CPD) credits to further training for current physicians in Canada.
5. Ongoing and timely review of current, evidence-based approaches to substance use disorder and its integration into medical training.

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