LEGISLATIVE ASSEMBLY
of BRITISH COLUMBIA

CLOSING GAPS, REDUCING BARRIERS: EXPANDING THE RESPONSE TO THE TOXIC DRUG AND OVERDOSE CRISIS

Select Standing Committee on Health

November 2022

First Report, Third Session
42nd Parliament

LEGISLATIVE ASSEMBLY
of BRITISH COLUMBIA

November 1, 2022

To the Honourable
Legislative Assembly of the
Province of British Columbia

Honourable Members:

I have the honour to present herewith the First Report of the Select Standing Committee on Health for the Third Session of the 42nd Parliament, *Closing Gaps, Reducing Barriers: Expanding the response to the toxic drug and overdose crisis*, as adopted by the Committee. This report covers the Committee's work in regard to the examination of the urgent and ongoing illicit drug toxicity and overdose crisis.

Respectfully submitted on behalf of the Committee,

Niki Sharma, MLA
Chair

Contents

Composition of the Committee

Members

Niki Sharma, MLA, Chair
Vancouver-Hastings

Shirley Bond, MLA, Deputy Chair
Prince George-Valemount

Pam Alexis, MLA
Abbotsford-Mission

Stephanie Cadieux, MLA
Surrey South *(to April 7, 2022)*

Susie Chant, MLA
North Vancouver-Seymour

Dan Davies, MLA
Peace River North *(from April 7, 2022)*

Sonia Furstenau, MLA
Cowichan Valley

Trevor Halford, MLA
Surrey-White Rock

Ronna-Rae Leonard, MLA
Courtenay-Comox *(from May 3, 2022)*

Doug Routley, MLA
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Harwinder Sandhu, MLA
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Terms of Reference

On April 4, 2022, the Legislative Assembly agreed that the Select Standing Committee on Health be empowered to examine the urgent and ongoing illicit drug toxicity and overdose crisis, and in particular:

1. The increasing toxicity of illicit drug supplies in British Columbia, including but not limited to, trends in the patterns of use of illicit drugs, the illegal drug market, the role of organized crime, and the rapid increase in toxicity coinciding with the COVID-19 pandemic;

2. The systems and services guiding government responses to illicit drug supplies and toxicity deaths and injuries in Canada (federal, provincial, territorial and local) and other jurisdictions; and

3. Relevant and recent reports, studies and examinations as the Committee deems appropriate.

That the Committee make recommendations with respect to:

1. Responding to the crisis with reforms and initiatives by the Province and local governments, including those which may require federal approval;

2. Continuing to build an evidence-based continuum of care that encompasses prevention, harm reduction, treatment, and recovery; and

3. Expanding access to safer drug supplies, implementing decriminalization, and disrupting illicit toxic drug supplies.

That, in addition to the powers previously conferred upon Select Standing Committees of the House, the Select Standing Committee on Health be empowered to:

a. appoint of its number one or more subcommittees and to refer to such subcommittees any of the matters referred to the Committee and to delegate to the subcommittees all or any of its powers except the power to report directly to the House;

b. sit during a period in which the House is adjourned, during the recess after prorogation until the next following Session and during any sitting of the House;

c. conduct consultations by any means the Committee considers appropriate;

d. adjourn from place to place as may be convenient; and

e. retain personnel as required to assist the Committee.

That the Committee report to the House by November 2, 2022, and that during a period of adjournment, the Committee deposit its reports with the Clerk of the Legislative Assembly, and upon resumption of the sittings of the House, or in the next following Session, as the case may be, the Chair present all reports to the House.

A Message from the Committee

As our Committee issues this report, nearly six British Columbians are dying due to the drug toxicity and overdose crisis every day and thousands more are suffering. Behind these numbers are people with full lives, their family members, friends, colleagues, and neighbours. Almost everyone in this province knows someone whose life has been touched by this crisis.

It is this staggering loss that gave urgency to our Committee's work. We felt compelled to hear from as many British Columbians as we could: those on the front lines of responding to the crisis, policy makers, researchers, loved ones, and critically, people who use or have used drugs.

This report seeks to share what we heard—the agony, frustration, and hope—and to put forward a suite of recommendations we agree are essential to the government's response. Many are actions that need to be taken immediately to save lives, and it is our Committee's hope that implementing them now will move BC out of this public health emergency.

Some will feel that our report doesn't go far enough; others, that it goes too far. This is to be expected, as this is a constantly changing, complex crisis.

While the Members of the Committee brought different perspectives and experiences, we shared a deep commitment to listening and learning. We were profoundly moved by what we heard: the daily struggles for people who use drugs and their desire for stability; the devastating impacts on loved ones; and the policies, programs, and people that are saving lives. As we considered the Committee's recommendations, we engaged in difficult conversations and grappled with what to put forward in very personal ways.

It is our belief that individuals and communities across the province need to come together with open minds and open hearts to turn the tide on this public health emergency. We know from our experience as a Committee that engaging in difficult conversations can challenge preconceived notions about what is driving this crisis, who is affected, and what should be done to address it.

Our Committee sincerely hopes that this report and these conversations will help put differences aside so that we can all work together on what matters most: saving lives.

Finally, our Committee would like to express its gratitude to every organization and individual who took the time to share their views and stories with our Committee, and for the many British Columbians who have contributed in a myriad of ways to our province's response to the drug toxicity and overdose crisis.

Executive Summary

The Select Standing Committee on Health (the Committee) was empowered to examine the urgent and ongoing illicit drug toxicity and overdose crisis, and to make recommendations with respect to:

- responding to the crisis with reforms and initiatives by the province and local governments;
- continuing to build an evidence-based continuum of care; and
- expanding access to safer drug supplies, implementing decriminalization, and disrupting illicit toxic drug supplies.

In undertaking its work, the Committee received briefings from government ministries, health authorities, and relevant agencies, and collected input through a public consultation. In total, it heard from 118 presenters and received 881 written submissions. The Committee makes 37 recommendations aimed at saving lives and moving BC out of the current public health emergency. In cases where work is already underway, the Committee calls for urgent expansion or acceleration of those efforts.

This report begins with a summary of the Committee's work and the information it heard during the briefings. It then includes several key principles that the Committee agreed must underpin the government's response to the drug toxicity and overdose crisis. These include:

- urgency
- equity
- comprehensiveness
- connection
- coordination
- standardization
- accountability
- inclusion of people who use drugs

These key principles inform all the Committee's recommendations and are reflected throughout this report. Each subsequent chapter begins with a summary of what the Committee heard during its public consultation on a particular theme, followed by a description of the Committee's related discussion and its recommendations. A glossary of terms is included in Appendix A.

Overarching Government Response

The report outlines some of the work underway; however, the Committee heard that there are critical gaps in the current continuum of care, some of which were exposed or made worse by the COVID-19 pandemic. To ensure supports and services are available throughout BC, the Committee recommends rapidly scaling up and expanding the continuum of care, as well as improving accountability by defining and publicly reporting on goals, metrics, and timelines. Committee Members recognize that regional health authorities are critical to ensuring accessible supports and services are available in all areas of the province. As such, the Committee recommends that the government more clearly articulate targets for expanding services and that it require regular public reporting on progress, as well as increases opportunities for collaboration between the health authorities. A striking gap in the substance use continuum of care that emerged during the Committee's examination was the frequency with which people who died due to illicit drug toxicity had recent contact with the health care system or government services. This includes visiting a health care professional, receiving social assistance payments, being recently released from prison, receiving services from WorkSafeBC due to a workplace injury, and receiving care from first responders following a toxic drug-related event. The Committee sees these as critical "touchpoints" to connect individuals at risk with lifesaving supports and services, and recommends that these missed opportunities be urgently identified and acted upon. The Committee also reflects

the sentiment it heard, "Nothing about us, without us," in its recommendation to include people who use drugs when designing programs and policies that will affect their lives.

Prevention and Education

The Committee is of the view that there are misconceptions about the key populations that are most impacted by this crisis, which include Indigenous people (especially women), men aged 19 to 39, and people working in the trades, in transportation, or as equipment operators. Most deaths are also occurring when individuals are alone and in private residences, and stigma continues to prevent people from seeking care. The Committee therefore recommends expanding public awareness and anti-stigma efforts developed with and tailored to these high-risk groups and others. In addition, upstream drivers such as income or housing insecurity, unresolved trauma, mental health challenges, and untreated chronic pain, can contribute to people using substances. The Committee makes several recommendations in this regard, including expanding the continuum of housing options, fully integrating mental health care into the primary health care system, and implementing a provincial pain strategy.

Harm Reduction

The Committee heard that services such as overdose prevention sites and drug checking are critical to reducing the harms associated with substance use and preventing deaths. Overdose prevention sites provide individuals with a sense of connection and offer opportunities to refer people to other services, including treatment; however, there remain communities without overdose prevention sites, sometimes due to local resistance. The Committee recommends that these sites and drug checking be treated in the same way as other health care services, by ensuring availability throughout BC and providing standards that require consistent quality care and safety for users. Recognizing that naloxone remains an important tool to reverse the effects of a toxic drug-related event in many cases, the Committee also recommends that the Take-Home Naloxone program be further expanded with a particular focus on those working in the trades, in transportation, or as equipment operators.

Safer Supply

BC has been at the forefront of providing individuals with a prescribed safer supply of substances since the government issued original guidance to prescribers in March 2020. The Committee supports the government's current policy as a way to save lives given the increasingly toxic drug supply and as part of the substance use continuum of care; however, the Committee heard about several challenges faced by those seeking a prescribed safer supply of substances. These include a lack of prescribers and barriers for users including the need for prescriptions, witnessed daily doses, and pharmaceutical alternatives that are not strong enough to prevent withdrawal symptoms or that are available in preferred modes of consumption, such as smoking. Noting the important role that the regulatory colleges and professional associations of physicians, nurse practitioners, nurses, and pharmacists play in BC's health care system, the Committee recommends urgent collaboration with these organizations to identify and resolve barriers to prescribing. It also recommends assessing the current policy and clinical guidelines for prescribing safer supply to limit barriers and to ensure a range of appropriate prescribed pharmaceutical alternatives are made available. The Committee recognizes the newness of the current approach, and that any change to the requirement for a prescription would require an exemption from the federal *Controlled Drugs and Substances Act*. As such, the Committee recommends that assessment and evaluation continue, and that the findings of these evaluations drive engagement with the federal government and decisions on whether alternative models of providing a safer supply of substances should be trialed to scale up the response.

Treatment and Recovery

The Committee heard that those seeking treatment for substance use face several barriers, such as waitlists, fees, and programs that do not account for the variety of circumstances in which people find themselves. It was repeatedly noted that when an individual is seeking care, it is imperative that services be immediately available. As such, the Committee recommends a substantial increase in publicly funded and accredited treatment and recovery beds and detox services, while ensuring a variety of treatment options exist that account for individual and family needs. Another issue raised was the lack of province-wide regulations and standards for treatment and recovery services, as well as a deficit of data which makes it impossible to monitor and report on outcomes. The Committee therefore recommends creating a new statutory framework solely dedicated to treatment and recovery services, as well as a privacy-informed system to collect and evaluate information on outcomes. Additional

recommendations made by the Committee aim to increase the number of people retained on opioid agonist treatment, modernize the *Mental Health Act*, and ensure that Canada's immigration rules do not prevent people from seeking support.

Enforcement and Decriminalization

While this crisis must be treated foremost as a health emergency, the Committee recognizes that enforcement of drug trafficking must be part of the broader response. The Committee acknowledges that law enforcement resources are limited, and as such recommends that overdose and mental health calls be redirected to more specialized responders where possible, as well as working with the federal government to combat the organized crime groups that are behind the importation and domestic production of illicit toxic drugs. The upcoming decriminalization of people in possession of small amounts of certain illicit substances is viewed as an important step in destigmatizing substance use and allowing people to receive important health and social services. Recognizing that this is a significant change to drug enforcement in BC and in Canada, the Committee recommends continued consultation with impacted groups and evaluation of outcomes, as well as ensuring that there is sufficient capacity for individuals who are not charged to be referred to substance use supports and services.

Indigenous People

The Committee heard that Indigenous people, and particularly Indigenous women, are disproportionately impacted by the crisis, and that substance use is driven by the ongoing impacts of colonialism, racism, and intergenerational trauma. To address this, the Committee recommends funding Indigenous-led and Indigenous-designed, trauma-informed, and culturally appropriate substance use supports and services. Recognizing the overrepresentation of Indigenous people in the criminal justice system, the Committee recommends working with the BC First Nations Justice Council to implement the BC First Nations Justice Strategy, which was signed in 2020. It also recommends reducing stigma and racism toward Indigenous people, guided by the actions identified in reports including *In Plain Sight*, which examined Indigenous-specific racism in the provincial health care system, and *Red Women Rising*, which includes the perspectives of Indigenous women in Vancouver's Downtown Eastside regarding the National Inquiry into Missing and Murdered Indigenous Women and Girls.

Youth

In BC, overdose is the primary cause of death for people aged 19 to 39 and the third most likely cause of death for those aged under 19 years of age. Early interventions in the lives of children and youth were identified as being essential to preventing substance use. The Committee recognizes that youth may experiment with substances for many reasons and recommends that standardized, trauma-informed prevention and education programs that include information on the risks of the toxic drug supply be urgently expanded in schools. The Committee further recommends funding to increase integrated mental health and substance use supports, including to evaluate children with neurodiverse needs, so that young people get the supports they need to prevent future substance use. Recognizing that many of the existing adult substance use supports and services are unsafe and unwelcoming to young people, the Committee also recommends funding supports and services that are tailored to youth.

Additional Measures

The Committee recognizes that community groups, such as non-profit organizations and community-led groups, including drug user groups, fill critical needs for supports and services throughout the province, and recommends that these organizations be provided with sustainable, multi-year funding to allow them to continue this important work. Responding to this crisis will also require additional health care and social services professionals, and as such the Committee recommends funding significant additional human resources capacity as well as ensuring trained personnel are available in hospital emergency rooms to refer individuals to harm reduction or treatment services. Additional recommendations from the Committee include expanding the supports and resources available to family members of people who use drugs, and expanding access to harm reduction services and evidence-based treatment and recovery options for individuals within and transitioning out of the provincial correctional system.

List of Recommendations

The following recommendations are listed in order of the report. Each chapter includes a Committee Discussion section, which provides explanation for the resulting recommendations.

The Committee recommends to the Legislative Assembly that the provincial government:

Overarching Government Response

1. Rapidly scale up a flexible, evidence-based, low-barrier, comprehensive continuum of care that spans the social determinants of health, prevention and education, harm reduction, safer supply, and treatment and recovery, and includes:
    a. housing, employment and income, and mental health supports;
    b. defined goals, metrics, and timelines;
    c. clear accountability mechanisms; and
    d. regular public reporting on results.

2. Leverage and strengthen existing mechanisms to hold the health authorities accountable for rapidly expanding harm reduction and treatment and recovery services throughout the province, including through:
    a. additional quantitative targets in mandate letters and service plans;
    b. requiring public reporting on those targets at least annually; and
    c. ensuring increased collaboration between health authorities.

3. Identify the "touchpoints" between government services and individuals at high risk from the toxic drug supply and develop an action plan to ensure these individuals are being referred to appropriate support services.

4. Fully integrate people who use or have used drugs into the development and implementation of new policies and programs that directly impact them and their peers, including youth; 2SLGBTQIA+ people; Indigenous people; rural and remote residents; parents; people working in the trades, in transportation, or as equipment operators; people with mental health challenges; and people who are experiencing homelessness.

Prevention and Education

5. Increase funding for expanded public awareness and anti-stigma initiatives that include information on the drug toxicity and overdose crisis, the risks associated with substance use, and available supports and services, ensuring that these initiatives are:
    a. tailored to high-risk groups;
    b. developed in partnership with relevant stakeholders, including WorkSafeBC;
    c. informed by the diverse voices of people with lived and living experience;
    d. available in multiple languages and formats throughout the province; and
    e. regularly evaluated to ensure effectiveness.

6. Increase funding for an expanded affordable and accessible continuum of housing options for individuals at all stages of substance use, including supportive housing programs that provide wraparound supports, and develop a toolkit of best

practices for supportive housing initiatives to ensure success and community support.

7. Fund and expand trauma-informed mental health care that is integrated into the primary health care system.

8. Prioritize the creation and implementation of a provincial pain strategy that includes evidence-based best practices for pain care and guidelines for the appropriate prescription of opioids.

Harm Reduction

9. Urgently ensure the availability of province-wide, standardized (in terms of resourcing, operating, and evaluating parameters) harm reduction services—including overdose prevention and drug checking services—and develop community-building measures to overcome local opposition.

10. Ensure ready access to take-home naloxone kits to all individuals, with a focus on distribution to high-risk populations, particularly those working in the trades, in transportation, or as equipment operators.

Safer Supply

11. Fund measures to ensure a prescribed safer supply of substances is available in all areas of the province, including by:
    a. urgently engaging with the regulatory colleges and professional associations of physicians, nurse practitioners, nurses, and pharmacists in BC to identify and resolve barriers to prescribing and providing a prescribed safer supply of substances;
    b. increasing education and ensuring clear clinical guidance is in place for prescribers; and
    c. addressing barriers, such as transportation, for individuals in rural and remote communities.

12. Review the policy direction on Prescribed Safer Supply and current and future clinical guidelines to limit restrictive barriers and to allow for a range of prescribed pharmaceutical alternatives to be provided, including options for inhalation.

13. As part of the ongoing evaluation of providing a prescribed safer supply of substances, work with the federal government to consider whether alternative models should be trialed or implemented in order to scale up the response.

Treatment and Recovery

14. Urgently fund a substantial increase in publicly funded, evidence-based, and accredited treatment and recovery beds and outpatient services, including managed withdrawal (detox) and aftercare supports, while ensuring a variety of treatment options to support individual and family needs.

15. Create new legislation to provide a statutory framework that encompasses all treatment and recovery services in British Columbia, along with appropriate regulations, standards, and protocols.

16. Create a provincial system to collect data from treatment and recovery services to increase oversight and determine effectiveness with clearly defined outcomes that can be evaluated and reported on publicly.

17. Fund measures to ensure opioid agonist treatment is available in all areas of the province, including by:
    a. urgently engaging with the regulatory colleges and professional associations of physicians, nurse practitioners, nurses, and pharmacists in BC to identify and resolve barriers to prescribing and providing opioid agonist treatment;
    b. increasing education and ensuring clear clinical guidance is in place for prescribers; and
    c. addressing barriers, such as transportation, for individuals in rural and remote communities.

18. Review the policy and clinical guidelines for providing opioid agonist treatment to limit restrictive barriers and to allow for a range of prescribed medications to be provided.

19. Within six months of this report's release, initiate a comprehensive review of the *Mental Health Act* that includes public input.

20. Work with the federal government to ensure that accessing treatment and recovery services will not jeopardize an individual's immigration status or application for permanent residency.

Enforcement and Decriminalization

21. Prioritize the modernization of policing in BC, as outlined in the recommendations made by the Special Committee on Reforming the Police Act, with particular attention paid to altering the role of police in responding to complex social and health matters and investing in health and social services.

22. Work with the federal government and port authorities to develop innovative solutions to disrupt the supply of illicit toxic drugs being imported and produced domestically by international and domestic criminal organizations.

23. Work with the federal government, in continued meaningful consultation with people who use drugs, law enforcement, Indigenous peoples, racialized communities, and other key stakeholders, to collect data to measure and evaluate:
    a. whether decriminalization at the approved threshold of 2.5 grams is effective in reducing the harms of criminalization, and
    b. whether the effects of decriminalization have any unintended consequences.

24. To support the successful implementation of decriminalization, advocate for an increase in funding from the federal government to ensure that there is sufficient capacity for police to refer individuals who are not charged to substance use supports and services.

Indigenous People

25. Fund Indigenous-led and Indigenous-designed, trauma-informed, and culturally appropriate services across the substance use continuum of care, including:
    a. prevention services that support children and their families with their mental health as well as children and youth who may be living with family members who use substances or struggle with addiction;
    b. harm reduction services, including those designed specifically to address the needs of Indigenous women, girls, two-spirit, transgender, and gender-diverse people;
    c. treatment and recovery programs, including in BC Corrections facilities; and
    d. mental health and social supports.

26. Prioritize engagement with the BC First Nations Justice Council to implement the BC First Nations Justice Strategy, including by transforming the criminal justice system, reducing the number of Indigenous people who become involved with the criminal justice system, and supporting Indigenous-led initiatives rooted in Indigenous culture and laws.

27. Use the recommendations from the *In Plain Sight* and *Red Women Rising* reports, the Calls for Justice from the National Inquiry on Missing and Murdered Indigenous Women, and the Calls to Action from the Truth and Reconciliation Commission as a guide for government action to reduce stigma and racism toward Indigenous people, especially Indigenous women.

Youth

28. Urgently expand in-school prevention and education programs that include information on the risks of the toxic drug supply and are trauma-informed, evidence-based, and standardized.

29. Fund universal access to integrated mental health and substance use supports for children, youth, and young adults, including:
    a. increasing the number of specialized school counsellors;
    b. expanding Integrated Child & Youth (ICY) teams; and
    c. implementing targeted initiatives for children and youth in care.

30. Fund additional resources to provide timely evaluations of children for attention deficit hyperactivity disorder (ADHD) and other neurodiverse needs so that they can receive the support they need.

31. Fund and implement a robust substance use continuum of care developed specifically for youth and young adults that includes equitable and safe access to harm reduction, safer supply, and treatment and recovery services, as well as wraparound supports that include supportive housing.

Additional Measures

32. Provide sustainable, multi-year funding to community groups, including non-profits and community-led (drug user) groups, that includes accountability measures to support people-centred outcomes.

33. To better leverage the deployment of first responders to mental health and substance use crises, explore alternative options, including crisis response teams, and integrate a mental health option in 911 calls.

34. Create and fund significant additional human resources capacity to respond to the drug toxicity and overdose crisis through the retention, recruitment, and training of new and existing health care and social services professionals and peers.

35. Ensure additional, designated personnel are available in hospital emergency rooms to provide referrals to harm reduction or treatment and recovery services for individuals who are at risk from the toxic drug supply.

36. Expand supports and resources to family members of people who use drugs, including those grieving the loss of a family member due to the drug toxicity and overdose crisis.

37. Expand access to harm reduction services and evidence-based treatment and recovery options for both those within and transitioning out of the provincial correctional system.

The Work of the Committee

On April 4, 2022, the Legislative Assembly empowered the Select Standing Committee on Health to examine the urgent and ongoing illicit drug toxicity and overdose crisis. To help guide the work of the Committee and provide input on meeting planning, the Committee appointed a Subcommittee on Agenda and Procedure comprised of the Chair, the Deputy Chair, and three Committee Members.

To gather input to support its examination, the Committee received briefings from relevant federal and provincial government ministries and agencies, the Provincial Health Officer, the BC Centre on Substance Use, the BC Centre for Disease Control, the BC Coroners Service, the First Nations Health Authority, the Provincial Health Services Authority, regional health authorities, and Providence Health Care. A summary of the briefings is available in the following chapter, and additional information is included in other relevant chapters.

To support its public consultation, the Committee invited stakeholders and subject matter experts to provide input through public hearings which were held between June 14 and September 9, 2022, in Victoria and Vancouver, as well as virtually. In addition, the Committee accepted written submissions from the public between June 28 and August 5, 2022. To advise the public of this, the Committee issued a province-wide news release, placed advertisements in local and multicultural newspapers and online, communicated through social media, and reached out directly to stakeholders.

In total, the Committee heard from 118 presenters and received 881 written submissions. A list of the individuals and organizations that presented at the briefings and public hearings is available in Appendix B. A list of the individuals and organizations that provided written submissions is available in Appendix C.

Meeting Schedule

April 6, 2022	Election of Chair and Deputy Chair, Planning
May 2, 2022	Briefings
May 4, 2022	Briefings
May 16, 2022	Briefings
May 24, 2022	Briefings
May 25, 2022	Briefings
June 14, 2022	Presentations
June 15, 2022	Presentations
June 16, 2022	Presentations
June 20, 2022	Presentations
June 21, 2022	Presentations
June 22, 2022	Presentations
July 4, 2022	Presentations
July 5, 2022	Presentations
July 6, 2022	Presentations
July 11, 2022	Presentations
July 12, 2022	Presentations
July 14, 2022	Presentations
August 2, 2022	Presentations
August 3, 2022	Presentations
September 6, 2022	Presentations
September 7, 2022	Presentations

September 8, 2022	Presentations
September 9, 2022	Presentations, Planning
September 29, 2022	Deliberations
October 3, 2022	Deliberations
October 4, 2022	Deliberations
October 5, 2022	Deliberations
October 6, 2022	Deliberations
October 13, 2022	Deliberations
October 14, 2022	Deliberations
October 17, 2022	Deliberations
October 21, 2022	Deliberations
October 24, 2022	Deliberations
October 27, 2022	Deliberations, Adoption of Report

Summary of Briefings

To gain a greater understanding of the context of the drug toxicity and overdose crisis, the Committee received briefings from relevant federal and provincial government ministries, the Provincial Health Officer, the BC Centre on Substance Use, the BC Centre for Disease Control, the BC Coroners Service, the First Nations Health Authority, the Provincial Health Services Authority, regional health authorities, and Providence Health Care. The following section provides a high-level summary of what the Committee heard during these briefings.

Overview of the Crisis

On April 14, 2016, BC's then-Provincial Health Officer, Dr. Perry Kendall, declared a public health emergency in response to the alarming rise in overdoses and deaths due to illicit drug toxicity. As noted by Dr. Bonnie Henry, BC's current Provincial Health Officer, the increasing availability of highly toxic, illegally produced opioid fentanyl analogues was resulting in more people taking drugs with an unknown potency, which led to an increase in deaths.

Tragically, more than 10,000 British Columbians have died from illicit toxic drugs in the six years following the declaration. According to the BC Coroners Service, illicit drug toxicity is the leading cause of unnatural death in BC, accounting for more deaths than homicides, motor vehicle incidents, drownings, and fire-related deaths combined. The BC Centre for Disease Control shared that between March 2020 and March 2022, illicit drug toxicity was the second-highest cause of years of potential life lost in BC, whereas COVID-19 ranked sixth.

While the drug toxicity and overdose crisis can affect everyone, the Committee heard that certain groups have been disproportionately impacted. The Ministry of Mental Health and Addictions outlined the following:

- First Nations people died at 5.4 times the rate of other BC residents in 2021.
- First Nations women died at 9.8 times the rate of other women in BC in 2021.
- 77 percent of people who died were male (as of May 2022).
- The average age of people who died is 42. Deaths due to illicit drug toxicity is the leading cause of death in BC among 19- to 39-year-olds.
- 35 percent of those who died were employed at the time of their death.
    - 52 percent of those who were employed worked in trades, in transportation, or as equipment operators.
- Over half of all people who died between 2017 and 2021 were alone at their time of death.

Further, the BC Coroners Service shared that 83 percent of illicit drug toxicity deaths in 2021 occurred inside and 56 percent occurred in a private residence.

In addition to deaths, the Committee also heard about other serious outcomes resulting from toxic drug-related events including serious and permanent brain injury. The Vancouver Island Health Authority stated that non-fatal toxic drug-related events result in disability and impacts to quality of life, anoxic brain injury, and other circulatory impacts to major organ systems. Further, Providence Health Care referenced significant morbidity and long-term brain damage.

Several presenters stated that the primary driver of the current number of deaths is the toxicity of the illegal drug supply. According to the BC Coroners Service, illicit fentanyl was first detected in four percent of drug toxicity deaths in 2012 but rose to 86 percent in 2021. The BC Provincial Toxicology Centre explained that fentanyl is 50 to 100 times more potent than heroin and can be produced at a lower cost and added that the metabolism and duration of effects for heroin is longer lasting than for fentanyl, resulting in individuals addicted to fentanyl needing more frequent dosing. The Centre also expressed concern about how drugs like fentanyl are being processed, stating that drug dealers often use "bulking agents" to disguise that fentanyl is being used in their drug production, and that drugs are not mixed using appropriate equipment or following sanitary guidelines. Further, if not mixed properly, parts of the sample can have dangerously high or fatal doses of fentanyl. The Committee also heard that multiple substances are often found to be present in those who have died due to illicit drug toxicity. Increasingly this includes benzodiazepines, which are particularly dangerous as they don't respond to naloxone. Dr. Jaime Arredondo Sanchez Lira told the Committee that beyond BC, fentanyl is now common to the drug supply throughout North America, while benzodiazepines are becoming more common in some areas of the United States.

In addition to the toxicity of the drug supply, the Committee heard about many other factors that have contributed to this crisis and reasons why people turn to illicit drugs, including homelessness, poverty, mental health issues, recent release from prison, or having been prescribed opiates for pain relief and no longer having a prescription. Given this broad range of underlying factors contributing to substance use and the diversity of the populations most impacted, the Committee heard about the need to encourage collaboration between many different ministries, agencies, organizations, and people with lived and living experience, and to ensure that care is trauma-informed and culturally appropriate.

Several presenters described the impact of the COVID-19 pandemic on the drug supply, overall mental health, and efforts to address the crisis. The BC Centre for Disease Control noted that significant, albeit incremental, progress was being made prior to the pandemic; however, after the introduction of public health measures in response to the pandemic, the immediate and precipitous drop in the number of visits to overdose prevention sites and a substantial decline in visits to health care services resulted in a sharp increase in illicit drug toxicity deaths. Dr. Bonnie Henry, Provincial Health Officer, noted the increased risk that resulted from people using drugs alone at home during the pandemic, as well as the impact that border closures had on increasing drug toxicity.

Response

During the briefings, the Committee also heard about some of the actions that have been taken in response to the crisis at the federal, provincial, and regional levels. Health Canada stated that the federal government is undertaking several initiatives to respond to the crisis. These include advancing the Canadian Drugs and Substances Strategy to address substance use harms in Canada; supporting provinces, territories, and Indigenous communities to improve access to evidence-based treatment and harm reduction services; and leading efforts to reduce stigma and creating national standards for substance use treatment programs. They noted that since 2017, the federal government has invested over $800 million nationally to address the crisis. In addition, Health Canada highlighted a number of pilot projects underway providing a safer supply of substances, including eight projects in BC.

At the provincial level, the Ministry of Mental Health and Addictions stated it is leading a cross-government response including several ministries, health authorities, and key partners such as the BC Centre for Disease Control and the BC Centre on Substance Use. The Ministry outlined several actions taken since the declaration of the public health emergency, including launching *A Pathway to Hope* in 2019 as a 10-year vision for a mental health and substance use system of care. The Substance Use System of Care, as committed to in *A Pathway to Hope,* describes all the elements needed to ensure that people with substance use challenges experience seamless and cohesive care with initiatives spanning the continuum of prevention and education, harm reduction, treatment and recovery, and systems of support. In terms of funding, the Ministry stated that the provincial government has invested $2.667 billion since the 2017/18 fiscal year in mental health and substance use services.

Regarding public safety, the Ministry of Public Safety and Solicitor General outlined several initiatives underway to address the crisis, including developing a BC Organized Crime Strategy; expanding Situation Tables involving multi-agency partners including social services, health, education, and police; and the Provincial Tactical Enforcement Priority Initiative to identify and target the most dangerous gang-affiliated individuals across the province, including those involved in illicit drug production and trafficking.

The Committee also heard from the health authorities about the challenges and issues they are facing in responding to this crisis and meeting the increased need for mental health and substance use services. Some of the challenges they described include limited access to addictions medicine, stigma, provision of culturally appropriate treatment, and a lack of health human resources. The Northern Health Authority has the highest rates of illicit drug toxicity deaths in the province and described challenges related to recruitment and retention of health care providers in the north as well as inconsistent access to harm reduction services and treatment across the region. The Committee also heard about challenges impacting the response in rural, remote, and northern areas, including vast distances between communities, small service centres, harsh climates, poor transportation systems, lack of cellular service, limited access to pharmacies, and potentially limited social, education, and employment opportunities.

The health authorities outlined several programs and initiatives they are undertaking with respect to prevention and outreach, harm reduction, treatment, reducing stigma, and ensuring access to services, as well as innovative approaches to provide care during the COVID-19 pandemic. They also described regional task forces, peer networks, and steering committees they have developed bringing together local stakeholders, including clinical operations, Indigenous partners, social service organizations, and peer representatives.

Key Principles

As the Committee undertook its deliberations and considered its recommendations, Members agreed to a set of key principles they felt should underpin the government's response to the drug toxicity and overdose crisis:

Urgency:

The toxicity of the drug supply and the number of people dying each day demands an emergency response, in line with that of the COVID-19 pandemic—this includes real-time responsiveness to an evolving landscape.

Equity:

British Columbians must have access to the full continuum of care and high-quality supports and services, no matter who they are or where they live in the province.

Comprehensiveness:

There is a need for a multitude of supports and services across the substance use continuum of care and to "meet people where they are at"—recognizing that a "one size fits all" approach does not work.

Connection:

That interactions with individuals assessed to be at risk from the toxic drug supply provide opportunities to connect them with community networks, resources, and supports.

Coordination:

Ministries, health authorities, government agencies, and other stakeholders must coherently coordinate efforts to ensure a seamless continuum of care.

Standardization:

There must be clear, evidence-based standards and oversight for service providers to ensure high-quality care and support for individuals.

Accountability:

There is a need for clearly articulated and measurable desired outcomes and public reporting thereon.

Inclusion of people who use drugs:

Policies and programs must be informed by the perspectives of people with lived and living experience.

Overarching Government Response

What the Committee Heard

Substance Use Continuum of Care

The Committee heard from numerous organizations and individuals that indicated that a more cohesive substance use continuum of care is needed. This needs to include prevention and education, harm reduction, safer supply, and treatment and recovery, as well as post-treatment supports. Dr. Danya Fast and others suggested that a continuum of care should also include housing, employment, social and other supports, in addition to various treatment options. Organizations, including the First Nations Leadership Council and qathet Community Action Team, suggested that coordination of services and information about treatment programs could be improved through a more centralized approach that could include provincial information on virtual and in-person services and supports.

The Cool Aid Society expressed that there is a need to recognize and address the role of systemic issues such as colonization, racism, poverty, and past trauma in order to provide a full range of options for individuals seeking substance use care based on cultural competencies, empathy, and awareness. Similarly, the John Howard Society of BC recommended that a continuum of ongoing care and supports be developed to ensure that services are individualized, holistic, compassionate, equitable, and low-barrier by adopting a "no wrong door" approach, meaning that no matter where an individual enters the system, they can gain access to the services and supports they need. The Federation of Community Social Services of BC suggested that a more balanced system of care needs to include a full spectrum of services, including upstream services and interventions for children and young adults in addition to downstream services such as crisis intervention and long-term treatment beds.

Emergency Response

Several organizations and individuals, including Dr. Bonnie Henry, Provincial Health Officer, expressed to the Committee that the magnitude of the drug toxicity and overdose crisis demands a scaled-up government response. Many pointed to how governments and societies responded to the COVID-19 pandemic as an example of what is possible in addressing a health emergency and suggested that a similar response is warranted to urgently reduce the number of deaths resulting from the toxic drug supply.

BC's Chief Coroner, Lisa Lapointe, noted that the public health response for the COVID-19 pandemic demonstrated a model for a public health emergency that is "urgent, evidence-based, responsive, directive, and publicly transparent," and recommended a similar evidence-based comprehensive substance use continuum of care to address the drug toxicity and overdose crisis. The BC Centre on Substance Use suggested that a substance use system of care is needed, which should include creating a mental health and substance use strategy, emphasizing primary care, building a sustainable interdisciplinary workforce, ensuring monitoring and improvement, removing silos between the public and private sectors, emphasizing recovery-oriented solutions, and addressing the stigma and shame associated with addiction.

Other organizations, such as the BC Federation of Labour, recommended implementing a public health strategy with defined goals, metrics, and accountability mechanisms, as well as regular public reporting. Some submissions pointed to the BC Coroners Service 2022 death review panel report on illicit drug toxicity deaths as providing clear next steps to address the crisis and expressed that the government should follow through on the report's recommendations. Benjamin Perrin acknowledged that

the polarizing nature of the drug toxicity and overdose crisis has inhibited the ability of governments to take bold actions and suggested that humanizing the issue could provide a way to depoliticize the issue.

Including People with Lived and Living Experience

The Committee heard about the importance of including people with lived and living experience as equal partners in decision-making and policy and program development. Professionals for Ethical Engagement of Peers and the People with Lived and Living Experience Committee, among others, noted the importance of taking a "nothing about us, without us" approach when designing drug policy, to ensure that people with lived and living experience are meaningfully consulted and integrated into the process of developing policies that impact their lives. The Vancouver Area Network of Drug Users called for real engagement with the community, and not just consulting one individual with lived and living experience, which the organization referred to as tokenizing.

Representatives from the Professionals for Ethical Engagement of Peers and People with Lived and Living Experience Committee noted that certain populations of people who use drugs face additional barriers to accessing appropriate services and supports, such as youth, 2SLGBTQIA+ people, Indigenous people, rural and remote residents, parents, people working in the trades, people with mental health challenges, and people who are experiencing homelessness, and suggested that their needs should be accounted for in the government's response.

Committee Discussion

Regarding the substance use continuum of care, Members agreed that it includes prevention and education, harm reduction, and treatment and recovery, as well as additional supports such as those related to housing, employment and income, and mental health. Members emphasized that attention needs to be paid to the social determinants of health, which play an important role in preventing substance use. The Committee agreed that individuals should be able to access a full spectrum of services, supports, and resources depending on where they find themselves on the continuum of care, and be able to easily move between options depending on their needs.

The Committee was united in its belief that the tragic number of lives that continue to be lost to the drug toxicity and overdose crisis underscores the need for a scaled-up, emergency government response. Members agreed that the scale of the crisis in British Columbia necessitates a response more akin to the response to the COVID-19 pandemic, in which sufficient resources were deployed, and focused, data-driven efforts were undertaken in real time across the province. Members noted concern that pilot projects are not reaching enough people with the support and services that are needed.

Some Members noted that significant actions have been taken since the crisis was declared a public health emergency in 2016, which have undoubtedly reduced the number of illicit drug toxicity deaths, and that this is the foundation from which to further scale up the government's response. They acknowledged the government's roadmap for mental health and addictions, *A Pathway to Hope*, and discussed the need for its strategy to include defined goals, metrics on services and treatment, and greater accountability mechanisms. Some Members suggested that there needs to be further clarity about whether the Ministry of Health or the Ministry of Mental Health and Addictions is ultimately accountable for delivering the government's response.

Members agreed that the magnitude of the crisis requires that the government provide regular updates to the public on the implementation and results of its strategy, similar to what was done at the height of the COVID-19 pandemic. They expressed concern that the majority of what the public hears about the crisis is from the BC Coroners Service's monthly updates on illicit drug toxicity deaths, but also recognized that the government makes announcements about new initiatives that may not receive the same attention. For these reasons, Committee Members felt that there is a need for more public reporting from both public health and government officials.

The Committee reflected on what it heard about some of the challenges impeding the government's current response. Members noted that they heard time and again that there is a need for increased access to life-saving harm reduction and

treatment and recovery services in many areas of the province, as well as improved coordination between different government ministries, health authorities, and other stakeholders. They expressed frustration that there continue to be disparities in available services in various parts of the province six years after the declaration of a public health emergency, despite the significant efforts and resources that have been committed to date.

Members recognized that the health authorities are responsible for many of the mental health and substance use services provided in their regions. They acknowledged that the health authorities have faced challenges resulting from other health care-related challenges such as the COVID-19 pandemic and a shortage of health care workers. However, the Committee was struck by what it heard from the health authorities themselves about how rarely they come together to share best practices and collaborate on issues related specifically to the drug toxicity and overdose crisis.

These concerns led the Committee to have an in-depth discussion about how to improve accountability for addressing the response to the drug toxicity and overdose crisis. While Members considered whether there is an alternative to the health authorities that could provide a more coordinated emergency response, they were reticent to create a new bureaucratic entity or to make major shifts in service delivery that could in any way delay the immediate actions that are required. Instead, Members agreed there is a need to provide the health authorities with clearer expectations for desired outcomes and to hold them accountable for meeting these expectations through mandated regular public reporting on specific targets and metrics.

Committee Members noted that the Minister of Health sends mandate letters to the Board Chair of each health authority, and that health authorities are required to develop service plans annually, which outline their priorities. However, the Committee suggested that these mechanisms could be strengthened with quantitative targets and clear timelines related to addressing the goals of the government's response to the drug toxicity and overdose crisis. Members questioned whether the Provincial Health Services Authority could play a stronger coordination role, given its mandate for the delivery of province-wide programs and services.

As part of its discussion on the government's response, the Committee was deeply concerned with what it heard about people who have died due to illicit drug toxicity that have had recent contact with the health care system or government services. For example, the Committee recalled:

- 72 percent of people who have died had a visit with a health professional less than three months before their death, and 30 percent had 10 or more visits in the three months prior to their death (Source: BC Coroners Service death review panel report);
- 44 percent of people who have died received a social assistance payment within a month of their death (Source: BC Coroners Service death review panel report); and
- people recently released from prison died at seven times the rate of other BC residents (Source: Ministry of Mental Health and Addictions).

This led Members to consider the "touchpoints" between individuals and government services that offer opportunities to make meaningful connections and referrals for those at greatest risk of dying from the toxic drug supply, and where these opportunities are currently being missed. Examples of touchpoints that were discussed include:

- Health care professionals
- Government service providers, including the Ministry of Social Development and Poverty Reduction and WorkSafeBC
- BC Corrections
- First responders
- Harm reduction service providers, including at overdose prevention sites

The Committee agreed that there is a need to comprehensively assess the many opportunities that exist for intervening to prevent illicit drug toxicity deaths, and to work with the health care sector and key government ministries and agencies to ensure employees receive appropriate education and training to refer and connect people with care. The Committee highlighted the idea of

a "warm handoff" approach, which typically refers to one health care worker ensuring a patient is immediately connected with another, specialized health care worker and can be accomplished through team-based care. However, the Committee expressed that this concept should be applied more broadly, to include that any service provider ensures an individual at risk is personally connected to another service provider, rather than leaving it upon the individual to make the connection on their own.

Committee Members found the presentations from people who use drugs to be very impactful and discussed how these presentations challenged their previously held perceptions. As such, they encourage all British Columbians to learn more and to listen to people who use drugs and their families to build greater empathy and understanding. Members appreciated hearing the unique perspectives and valuable input provided by these groups and individuals and agreed that people with lived and living experience must be meaningfully involved in policy development.

To ensure substance use services are being delivered equitably and effectively across the province, the Committee recognized the need for the response to include the perspectives of impacted populations that have unique perspectives on the crisis and necessitate tailored responses, such as youth, 2SLGBTQIA+ people, Indigenous people, rural and remote residents, parents, people working in the trades, in transportation, or as equipment operators, people with mental health challenges, and people who are experiencing homelessness.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

1. Rapidly scale up a flexible, evidence-based, low-barrier, comprehensive continuum of care that spans the social determinants of health, prevention and education, harm reduction, safer supply, and treatment and recovery, and includes:
    a. housing, employment and income, and mental health supports;
    b. defined goals, metrics, and timelines;
    c. clear accountability mechanisms; and
    d. regular public reporting on results.

2. Leverage and strengthen existing mechanisms to hold the health authorities accountable for rapidly expanding harm reduction and treatment and recovery services throughout the province, including through:
    a. additional quantitative targets in mandate letters and service plans;
    b. requiring public reporting on those targets at least annually; and
    c. ensuring increased collaboration between health authorities.

3. Identify the "touchpoints" between government services and individuals at high risk from the toxic drug supply and develop an action plan to ensure these individuals are being referred to appropriate support services.

4. Fully integrate people who use or have used drugs into the development and implementation of new policies and programs that directly impact them and their peers, including youth; 2SLGBTQIA+ people; Indigenous people; rural and remote residents; parents; people working in the trades, in transportation, or as equipment operators; people with mental health challenges; and people who are experiencing homelessness.

Prevention and Education

What the Committee Heard

Public Awareness and Education

A common theme that emerged during the Committee's examination was the importance of early interventions aimed at preventing substance use, such as prevention and education programs. Several organizations discussed the need to prioritize these early intervention efforts.

The need for public education on the dangers of the current drug supply and risks of drug use, along with education on supports and services for those seeking substance use care was highlighted by several organizations. Clive Weighill, Chief Coroner with the Saskatchewan Coroners Service, noted that despite public messaging and media coverage, the public does not understand the reality of the drug toxicity and overdose crisis and holds stereotypical views about who is most impacted by it.

The South Asian Mental Health Alliance noted the importance of ensuring public information is made available in a variety of languages, and suggested it is beneficial to provide audio and video content in multiple languages, in addition to the more standard practice of translating written documents.

Stigma

Several organizations and individuals raised concerns about the stigma directed towards people who use drugs, with many noting that this stigma is exacerbating the drug toxicity and overdose crisis and that reducing stigma must be an essential part of prevention and education efforts. It was noted that people use drugs for many reasons including coping with trauma, social connection, preventing withdrawal symptoms, and for recreation, and that anyone who uses drugs faces a heightened risk of death due to the toxic drug supply.

> *Stigma is killing people in this province. As a society, we don't care about people who use substances in the same way we care about people with other health conditions and we need to change that.* (Dr. Patricia Daly, Chief Medical Health Officer, Vancouver Coastal Health Authority)

A common theme to emerge during the Committee's public consultation was that stigma is undermining the response to the ongoing drug toxicity and overdose crisis. For example, the Mental Health Commission of Canada found that stigma may cause people who use opioids to be viewed as unworthy and undeserving of relief, while the Vancouver Coastal Health Authority noted that because of stigma, people who use illicit substances are not always cared for in the same way as those with other health conditions.

Several organizations and individuals outlined that stigma leads to feelings of isolation, disconnection, and rejection and can consequently prevent people from connecting with life-saving harm reduction services. Students Overcoming Substance Use Disorder and Addictions noted that the shame associated with stigma is causing people to avoid alerting their loved ones or social circle of their drug use, which makes them more likely to engage in higher risk behaviours like using drugs alone.

West Coast LEAF outlined concerns regarding how drug use by parents is stigmatized and suggested that this stigma should

be examined, including by the Ministry of Children and Family Development to guide its actions with respect to child protection. The organization further noted that parents may avoid harm reduction services, including seeking a prescribed safer supply of substances, out of fear that their child may be apprehended. The Ministry of Children and Family Development stated that keeping families together is a priority and noted that parental substance use on its own is not a child protection issue unless there is a concern of harm or likelihood of harm to a child.

Many organizations and individuals expressed a desire to see reduced stigma towards people who use drugs and called for education campaigns to increase empathy and understanding. In this regard, some submissions recommended overhauling communications strategies to reduce stigma and create better opportunities to improve public understanding of the root causes of substance use and addiction. The Public Health Association of BC called for increased efforts to reduce stigma, adding that cultural sensitivity and involving people with lived and living experience should be considered in the development of programs and campaigns. Health Canada noted that the federal government has expanded awareness around opioids and the harms of stigma through a variety of communication campaigns, resource kits, and programs, including a campaign aimed at men working in the trades, and that the federal government has continued to engage with law enforcement to promote uptake of the online Drug Stigma Awareness Training Module. While discussing how to reduce stigma, the Professionals for Ethical Engagement of Peers highlighted the importance of ensuring people who use drugs are accepted and supported.

Organizations also spoke about the prevalence of stigma in newcomer and minority communities, some of which have seen an increase in illicit drug toxicity deaths. Richmond Addiction Services Society noted that the newcomer and minority populations in Richmond have been more resistant to discussing mental illness and substance use and suggested that the sense of shame resulting from stigma can have deadly consequences. Students Overcoming Substance Use Disorder and Addictions noted heightened stigma towards substance use within the South Asian community and acknowledged addressing this stigma is one of its biggest priorities. The South Asian Mental Health Alliance stated that such stigma can be compounded by the additional biases faced by newcomers to Canada, especially those with language barriers, which can deter these individuals from seeking medical assistance or other services when they may need them.

Social Determinants of Health

Several individuals and organizations discussed the need to address the root problems of substance use, highlighting that the social determinants of health, such as economic stability, education, and access to health care, need to be considered when addressing this crisis. For example, Doctors of BC stated that prevention efforts must include increased access to health and social services that address the social determinants of health, including those that support mental health, stable housing, and secure employment.

Another common theme was that lack of housing and economic instability are contributing to the drug toxicity and overdose crisis. The BC Federation of Labour noted that the BC Coroners Service 2022 death review panel report on illicit drug toxicity deaths found that 44 percent of those who died of toxic drugs received income assistance in the month prior to their death and 31 percent were experiencing homelessness or living in shelters or in low-income housing. It suggested that poverty and housing insecurity should be addressed by strengthening TogetherBC, the provincial poverty reduction strategy. Further, the Committee heard calls for affordable housing to prevent homelessness and potential drug use, low-barrier supportive housing for people who use drugs to provide stability, and safe sober housing for recovering people who use drugs to reduce risk of relapse. The Castlegar & District Community Services Society stated that creating more housing for lower income people is a practical and effective way to support people who use drugs and those who are in recovery. With respect to supportive housing, Pacifica Housing Advisory Association shared that having health supports built into supportive housing leads to a reduction in emergency room visits and helps bridge the gap between residents and the health care system. Many British Columbians called for increases to social assistance and disability rates to prevent poverty and potential drug use.

Mental Health Supports

The connection between the drug toxicity and overdose crisis and mental health was noted by many who engaged with the Committee, with some pointing to the BC Coroners Service 2022 death review panel report on illicit drug toxicity deaths that found almost two thirds of people who died due to illicit drug toxicity were experiencing mental health issues at the time of their death. Others suggested trauma as a driver of potential substance use, with the Central Interior Native Health Society stating that substance use is a symptom of trying to treat underlying trauma. With respect to accessing mental health supports, the Committee heard that mental health options and resources are currently inaccessible due to financial barriers, the need for referrals, and waitlists. Additionally, the British Columbia Psychological Association stated that accessing mental health care in the province continues to be a challenge particularly for those who are most vulnerable. As a result, several organizations recommended increasing the availability of trauma-informed mental health supports and services.

The Committee also heard from the Crisis Intervention and Suicide Prevention Centre of BC that, while crisis lines do not tend to get calls directly involving opioid overdose, 15 percent of their crisis calls come from people where substance use is either the primary issue or a contributing factor to their crisis, and the Centre has seen a doubling of opioid-related calls where suicide is a factor or fentanyl is identified as a potential method of suicide since 2021. The Centre noted that the government's response to the drug toxicity and overdose crisis has not considered those dealing with suicide in the context of substance abuse.

Early Identification of Substance Use and Mental Health Disorders

Several organizations discussed the need for better screening for, and early identification of, substance use and mental health disorders. The BC Centre for Disease Control highlighted the finding of the BC Coroners Service 2022 death review panel report on illicit drug toxicity deaths that 72 percent of those who died due to illicit drug toxicity between 2017 and 2021 had accessed the health care system less than three months before their death, and shared that substantial improvement needs to be made within health care to prevent death. Further, organizations such as BC Emergency Health Services and the BC Coroners Service noted that early screening and identification of individuals at risk of substance use could help connect them with services and supports earlier on.

The Vancouver Coastal Health Authority indicated that improved screening and diagnosis for individuals with concurrent mental health and substance use disorders would be beneficial. The Committee heard from a group of physicians with expertise in attention deficit hyperactivity disorder (ADHD), which explained that early recognition and treatment of ADHD reduces the risk of developing a substance use problem by 30 to 50 percent. They noted many benefits of recognizing and treating ADHD in people with substance use disorder, including improving retention in substance use treatment programs, reducing relapses, and increasing employment rates.

Pain Management

The Committee heard the need to develop a provincial pain strategy to prevent the overreliance on opioids to treat pain. Pain BC highlighted the complex relationship between substance use and chronic pain, including that substance use increases the risk of developing chronic pain by altering the nervous system to be more pain sensitive. Pain BC stated that untreated pain is a significant driver of substance use and overdose risk and, to date, government and health authority interventions created in response to the overdose crisis have largely ignored pain care. Similarly, Dr. Bonnie Henry, Provincial Health Officer, indicated that many individuals could be self-medicating due to untreated chronic pain. Committee Members heard from a number of organizations, including Pain BC, Resident Doctors of BC, and the Provincial Health Services Authority, that highlighted the need for more training on substance use and chronic pain management for health care providers so they can better support British Columbians. Additionally, the Committee heard the need to ensure return-to-work polices better support injured workers in their recovery, with the BC Federation of Labour highlighting the connection between substance use and injured workers being required to return to work too soon.

People Working in the Trades, in Transportation, or as Equipment Operators

Representatives from the Construction Industry Steering Committee on the Opioid Epidemic stated that the construction industry has been devasted by the crisis, noting that the industry remains overwhelmingly staffed by men, which aligns with the demographics of those most impacted by the crisis. Further, the Council of Construction Associations pointed to high rates of chronic pain and recreational drug use in the sector. The Committee also heard that a workplace culture of "work hard, play hard" is a contributing factor to this overrepresentation. Construction Industry Rehabilitation Plan referenced the "macho culture" in the industry and shared that being overwhelmed is viewed as being weak and not up to the job. The Committee also heard about barriers that stop people in the industry from seeking help, including stigma and zero-tolerance substance use policies created because of the industry's safety risks.

The South Asian Mental Health Alliance and Students Overcoming Substance Use Disorder and Addictions told the Committee that they have heard examples of employers encouraging their workers to take illicit substances to increase alertness.

> *Our industry has been devastated by the opioid epidemic, and I don't think it's overstating it to say that the industry is in crisis. There is not a meeting that I attend anymore where somebody at the table is not telling me about another worker — a funeral they've had to go to, because they've buried another worker — or a colleague or a friend that overdosed recently.* (Vicky Waldron, Executive Director, Construction Industry Rehabilitation Plan)

The Committee heard about efforts to address substance use by workers. WorkSafeBC explained that its construction high-risk strategy is designed to prevent serious and fatal injuries in the construction industry, thereby reducing the number of workers requiring a prescription for opioids. WorkSafeBC has also adopted a harm reduction strategy that focuses on preventing the chronic use of opioids, including by working with prescribers to provide treatment alternatives for workers with chronic pain and/or addiction and by supporting both prescribers and injured workers in decreasing chronic usage when possible. Further, the Vancouver Island Construction Association provided an overview of its "Tailgate Toolkit," which includes worksite talks with employees, print and digital resources, and training for supervisors to address the crisis within the industry.

Committee Discussion

Members reflected on the Committee's own journey to learn about the complexity of the current public health emergency and acknowledged that the public needs to be brought along in a similar way through public awareness and education campaigns. The Committee highlighted that public awareness campaigns should include the dangers of the current drug supply, the risks of substance use, how to access services and supports, information about the government's response, and stigma reduction.

In discussing stigma, Committee Members reflected on the importance of changing public attitudes towards people who use drugs and people with addictions. Further, they noted that our society needs to understand that the crisis is having an impact across the province and not only in Vancouver's Downtown Eastside, as is sometimes believed. As such, Members discussed ways to increase public awareness and understanding about the root causes of addiction as well as the impacts of stigma. Members agreed that those most impacted by stigma must be involved in promoting public awareness, as ill-informed communications or education materials, and those that portray stereotypical imagery and messaging, can further exacerbate stigma and be dehumanizing. They emphasized the need to share individual stories and experiences to put a human face to these issues and to reduce stigma.

The Committee discussed the need for public awareness campaigns to be tailored to particular groups that are most impacted by the drug toxicity and overdose crisis, such as people working in the trades, in transportation, or as equipment operators, men, and Indigenous people (especially women),

and that these campaigns should target all age groups and all areas of the province and be provided in multiple languages. The Committee was concerned to hear that some employers may encourage workers to use substances to increase alertness. Committee Members highlighted the need to work with key stakeholders in the creation and the implementation of public awareness campaigns to ensure that information is accessible, applicable, and effective. This includes sector-specific outreach initiatives for prevention and education campaigns such as the construction industry's "Tailgate Toolkit." Members stressed that there needs to be feedback and continued assessment of these public awareness and education campaigns to ensure they are having the intended impact and are effectively reaching the right people.

The Committee discussed how the social determinants of health need to be considered when trying to prevent substance use. In particular, Members noted that housing is an important part of the continuum of care. They further emphasized that housing must be a safe place that creates a community and that there needs to be different options for housing, including low-barrier options. With respect to supportive housing, the Committee emphasized the need for 24/7 wraparound supports for individuals dealing with substance use, which should include clinical support and take care of their daily needs. Members acknowledged that supportive housing initiatives often have trouble getting community support. Therefore, they discussed the creation of a toolkit of best practices to help operators build supportive housing and gain community support. Further, Members discussed the need to have accountability measures in place to ensure that housing and supportive housing initiatives are being adequately resourced and are providing effective supports.

The fact that almost two thirds of people who died due to illicit drug toxicity were experiencing mental health issues at the time of their death underscored for Members the link between mental health and substance use. As traumatic experiences increase the risk of substance use if individuals do not receive appropriate supports, Members expressed the need for trauma-informed mental health care. Members noted that financial barriers and inaccessibility due to waitlists were the two main barriers for accessing mental health supports. Therefore, the Committee agreed to the importance of providing affordable and accessible mental health care that is integrated into the primary health care system.

With respect to pain care, the Committee reflected on the relationship between substance use and chronic pain. Members focused on the need for better pain management to prevent substance use and reliance on opioids. Members stated that there is a need for very clear guidelines on pain management including the appropriate use of opioids for pain care. Relating to this, Members discussed that workers who are required return to work too soon following an injury can turn to self-managing pain and reliance on opioids, and agreed WorkSafeBC should do more to address the impact of the crisis in the construction industry, including by helping to reduce stigma.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

5. Increase funding for expanded public awareness and anti-stigma initiatives that include information on the drug toxicity and overdose crisis, the risks associated with substance use, and available supports and services, ensuring that these initiatives are:
    a. tailored to high-risk groups;
    b. developed in partnership with relevant stakeholders, including WorkSafeBC;
    c. informed by the diverse voices of people with lived and living experience;
    d. available in multiple languages and formats throughout the province; and

e. regularly evaluated to ensure effectiveness.

6. Increase funding for an expanded affordable and accessible continuum of housing options for individuals at all stages of substance use, including supportive housing programs that provide wraparound supports, and develop a toolkit of best practices for supportive housing initiatives to ensure success and community support.

7. Fund and expand trauma-informed mental health care that is integrated into the primary health care system.

8. Prioritize the creation and implementation of a provincial pain strategy that includes evidence-based best practices for pain care and guidelines for the appropriate prescription of opioids.

Harm Reduction

What the Committee Heard

Access to Harm Reduction Services

A common theme to emerge during the Committee's examination was that harm reduction services, which minimize the harms related to substance use, should be made more widely available. Several organizations and individuals commented that these services are currently located primarily in urban areas, with less availability in rural and remote communities. The Northern Health Authority did however note that progress is being made in its region, with at least some level of harm reduction services now provided in every community in the north.

It was also recommended that harm reduction services should be available to people when and where they need them. For example, Cool Aid Society suggested mobile outreach and van-based services can more effectively reach people than static spaces. The Bridge Youth and Family Services shared that they have a vending machine that provides harm reduction supplies and gets significant use because it allows for a level of anonymity that helps reduce the stigma of accessing these resources.

Certain populations were identified as having a need for specific harm reduction services. The AESHA (An Evaluation of Sex Workers' Health Access) Project noted that sex worker-led and sex worker-specific services are critical, but often restricted by limited funding or overly restrictive conditions. Several construction-related organizations noted the need for harm reduction services in the industry, with the Vancouver Island Construction Association observing that a more coordinated approach could ensure that resources are allocated most appropriately. The Rural Empowered Drug Users Network suggested that harm reduction services need to be tailored to the unique needs of each community, and developed with local input.

Several barriers to accessing harm reduction services were identified. Some organizations and individuals criticized certain municipalities for making zoning decisions and denying business licenses that limit where harm reduction facilities can be located, as well as for implementing bylaws that prevent carrying harm reduction supplies. The Fraser Health Authority noted that it has experienced significant municipal opposition to setting up fixed harm reduction services in some communities, including direct opposition to locating sites in downtown areas where they would most benefit the clients they are meant to serve. Pivot Legal Society and others recommended that the government should clarify that municipalities require provincial approval to make decisions that impact public health. A few submissions also noted that a police presence near harm reduction facilities can deter individuals from using their services because they fear arrest.

Some organizations and individuals, including the Umbrella Society, the Drug Prevention Network of Canada, and Westminster House Society, suggested that the government is currently dedicating too many resources to harm reduction initiatives, at the expense of other interventions like prevention or treatment services. The BC Association of Chiefs of Police acknowledged that harm reduction is an important part of the short-term response to the drug toxicity and overdose crisis but noted that it is also necessary to address the underlying causes of substance use, such as trauma.

Supervised Consumption and Overdose Prevention Services

Supervised consumption and overdose prevention services provide monitoring for people at risk of an overdose, allow for rapid response in the case of an overdose, and provide other harm reduction services and supplies. Each site provides various levels of services, including overdose prevention education and take-home naloxone training and distribution. Some sites may also distribute harm reduction supplies, offer safe disposal options, provide drug checking, and facilitate referrals to mental health and substance use services. While supervised consumption sites require approval from the federal government, overdose prevention services do not require federal approval and are managed by the health authorities in co-operation with community partners. According to the Ministry of Mental Health and Addictions, there are currently 42 publicly available supervised consumption and overdose prevention sites in the province, and since 2017, there have been more than 3 million visits to these sites. The BC Centre for Disease Control reported that visits to supervised consumption and overdose prevention sites fell at the outset of the COVID-19 pandemic, but have since recovered. They noted there have not been any deaths at these sites.

Several organizations noted the importance of supervised consumption and overdose prevention services. The Fraser Health Authority suggested that these sites offer a safe, non-judgmental space for people who use drugs who otherwise face stigma when interacting with health care services, while Peers Victoria noted that in the absence of these services, individuals are forced to use drugs in riskier ways, such as alone, where an overdose response is unlikely. Dr. Bonnie Henry, Provincial Health Officer, suggested that overdose prevention sites offer an important source of connection, including a place where people can feel safe to talk about their substance use.

As such, many organizations and individuals recommended that there should be additional supervised consumption and overdose prevention sites, particularly in communities that do not currently have access to these services. Pivot Legal Society pointed to order M-488, issued by the Minister of Health in 2016, which required that overdose prevention services exist throughout the province, and noted that this order is not currently being met. The Rural Empowered Drug Users Network added that overdose prevention services are greatly lacking in most rural areas, while the Fraser Health Authority noted there are no publicly accessible overdose prevention sites in Maple Ridge, Burnaby, or the Tri-Cities.

The Committee heard about additional limitations, including the services provided at these sites. Several submissions noted the increasing number of individuals who prefer to smoke or inhale substances rather than to inject or ingest them; however, supervised consumption and overdose prevention sites rarely include facilities for smoking or inhaling substances. The Ministry of Mental Health and Addictions indicated the expansion of inhalation facilities is a current strategic priority, and that 13 sites have been established. The People with Lived and Living Experience Committee shared that supervised consumption sites are designed to help opioid users, and therefore the environment is not conducive to stimulant use. Others acknowledged that limited operating hours and certain requirements for using the services can present additional barriers. The John Howard Society of BC suggested episodic overdose prevention services, in which trained health and social service professionals provide harm reduction services outside of fixed sites, should be increased.

Other Harm Reduction Services

The Ministry of Mental Health and Addictions shared that, by providing information about drug contents, drug checking allows individuals to make informed choices about their use of substances, provides an opportunity for referral to other harm reduction services or the health care system, and supports surveillance of the illicit drug supply and identification of trends. The BC Coroners Service noted that it often finds a mix of drugs in the bodies of individuals who have died because of drug toxicity, suggesting there was a lack of knowledge about the drugs they purchased and consumed on the street.

Many organizations and individuals noted that free drug checking services should be more widely available in terms of locations, hours of operation, and proximity to transit, to allow for convenient use. Some observed that these services are particularly important for people who use drugs recreationally, and as such should be made available at universities and colleges, walk-in

clinics, and festivals. The BC Pharmacy Association suggested that drug checking test strips could be made available at pharmacies across the province.

Naloxone was described by many as a successful harm reduction tool, given the widespread distribution of naloxone kits in recent years. The BC Centre for Disease Control, which runs the province's Take Home Naloxone program, shared that there are currently more than 1,900 naloxone distribution sites in BC, and that more than 113,000 kits have been used to successfully reverse an overdose. The federal government noted that in March 2021, Health Canada provided $20 million in funding to organizations across Canada for the distribution of take-home naloxone kits and opioid overdose response training.

Many recommended that access to naloxone kits should be further expanded. Representatives from the Construction Industry Steering Committee on the Opioid Epidemic shared their desire to provide a naloxone kit to every construction worker in the province, given that those working in the industry continue to be overrepresented in illicit drug toxicity deaths. Others, such as Emergent Biosolutions and the Ambulance Paramedics and Emergency Dispatchers of BC, suggested nasal naloxone should be made more widely available since it is easier to use than injection-based naloxone.

The Committee also heard about technological solutions that play an important role in harm reduction. For example, the Lifeguard app automatically connects an individual to emergency responders if they become unresponsive while using drugs. The Ministry of Mental Health and Addictions indicated the app now has more than 10,000 unique users and has been used more than 100,000 times. BC Emergency Health Services stated that the app has provided significant benefits to paramedics, who have been dispatched more than 130 times since it was launched two years ago. The Engaged Communities Canada Society shared that the Overdose Intervention app provides multilingual information on identifying and responding to an overdose and has helped to expand harm reduction resources to additional cultural communities.

Committee Discussion

The Committee agreed that harm reduction services are an essential component of the province's emergency response to the ongoing crisis, given their role in preventing deaths from the toxic drug supply. It was noted that a full range of harm reduction services is needed in order to respond to the needs of diverse populations at risk, including overdose prevention sites and services, drug checking services, naloxone kits, and apps such as the Lifeguard app. Members expressed hope that with increased investments across the substance use continuum of care, the current emergency need for increasing harm reduction services may be lessened over time.

Members underscored that harm reduction services have been successful in saving lives, in part due to the efforts of many organizations filling needs in their communities. However, it was noted that the scaling-up of overdose prevention sites has resulted in a lack of consistency, which can create barriers for users who may feel unwelcome or unsafe and may contribute to community resistance. As such, the Committee agreed that these sites should be modeled after and supported in the same way as other health care services. This includes the need to provide sustainable funding, and to establish provincial standards that ensure consistent quality care and safety for users. Such standards should be developed in consultation with people with lived and living experience and should include accountability mechanisms for service providers as well as continued data collection and evaluation to ensure that the desired outcomes are being achieved.

Members recalled that the overdose prevention sites operated by the Overdose Prevention Society are fulfilling important community needs, including by providing employment for people, holding memorials, and providing a variety of services including washrooms. The Committee agreed that there is a need for a range of overdose prevention services, including options for inhaling substances and episodic overdose prevention services.

Members expressed concern about the lack of equitable access to harm reduction services across the province and acknowledged the high number of recommendations that they received to expand access to overdose prevention services. They agreed

that the Minister of Health's 2016 order that required overdose prevention services to be provided throughout the province is not currently being fulfilled. It was identified that one reason for this is that overdose prevention sites often face strong local opposition. Members acknowledged that municipal governments face many pressures related to the drug toxicity and overdose crisis, such as adequately resourcing first responders and clean-up of needles and other drug paraphernalia, but agreed there is a need for them to show leadership by ensuring life-saving harm reduction services are available in their communities. In this regard, it was suggested that community-building measures such as expert teams or toolkits could be deployed to assist communities in effectively building support for and establishing overdose prevention sites.

In addition to overdose prevention services, Members noted drug checking services as a particularly important harm reduction tool given the increased toxicity of the drug supply and recognized that there are still many communities that lack access to spectroscopy instruments.

The Committee noted that naloxone has been critical to reducing deaths from the toxic drug supply and was alarmed that the increasing prevalence of benzodiazepines is rendering it ineffective in some cases. That said, Members felt that naloxone remains an important harm reduction tool. They agreed with stakeholders in the construction industry that take-home naloxone kits should be made available to all individuals working in the trades, in transportation, or as equipment operators in addition to other interventions targeted at this population, given their overrepresentation in illicit drug toxicity deaths. Members also agreed that access to nasal naloxone should be expanded.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

9. Urgently ensure the availability of province-wide, standardized (in terms of resourcing, operating, and evaluating parameters) harm reduction services—including overdose prevention and drug checking services—and develop community-building measures to overcome local opposition.

10. Ensure ready access to take-home naloxone kits to all individuals, with a focus on distribution to high-risk populations, particularly those working in the trades, in transportation, or as equipment operators.

Safer Supply

What the Committee Heard

Benefits of Safer Supply

The Committee heard from several organizations and individuals that providing a safer supply of substances is a necessary intervention to protect people who use drugs from the toxic drug supply. In this regard, the BC Coroners Service stated the first priority in addressing the drug toxicity and overdose crisis is to keep people alive. Similarly, Moms Stop the Harm told the Committee to consider the question—"How do we stop people from dying?"—and that increased access to safer supply can buy time for people who use drugs and their families or support networks to explore other options to improve their lives.

> *Many people [that] are using drugs … are not ready for treatment. They may never be, or they may be in a period of time. So safe supply is still the number one recommendation of the [death review] panel in terms of what will save the most lives in a very short time frame.*
> (Lisa Lapointe, Chief Coroner)

In addition to preventing harms related to the toxic drug supply, several other benefits of safer supply were presented. Some noted that individuals receiving a safer supply of substances are liberated from the daily struggle to seek out and secure drugs to avoid withdrawal symptoms and can also lead to increased engagement with health care and social services, as well as family and community. The Public Health Association of BC shared that the provision of unadulterated substances in known concentrations could help to combat the increasingly toxic drug supply by undercutting the illicit market. Others suggested that providing a safer supply of substances could reduce criminal activity and homelessness.

Prescribed Safer Supply

According to the Ministry of Mental Health and Addictions, Risk Mitigation Guidance (RMG) was released in March 2020 as an urgent harm reduction measure in response to the impact of COVID-19 on the drug toxicity and overdose crisis and provided direction to clinicians on how to offer a prescribed safer supply of substances. Following that, the Ministry released a policy direction on Prescribed Safer Supply (PSS policy) in July 2021, which expanded the range of substances that could be prescribed and directed the health authorities to include providing a safer supply of substances in their services. The number of prescribers has increased from 17 in March 2020 to more than 1,000 in March 2022. Given the newness of this intervention, the Ministry noted that evaluation and monitoring is underway, and initial findings suggest that a prescribed safer supply of substances prevents mortality.

The federal government noted that it has provided support for eight safer supply projects in BC and supported regulatory changes to improve access to medications used in treatment and safer supply, including injectable hydromorphone, diacetylmorphine, and methadone. Health Canada is also supporting an independent preliminary assessment of 10 safer supply projects in Ontario, BC, and New Brunswick to support knowledge exchange and build evidence, among other initiatives.

Many organizations and individuals expressed that a key impediment to the success of the PSS policy is the lack of available prescribers, which are presently limited to physicians

and nurse practitioners. In their evaluation of the implementation of RMG, Drs. Karen Urbanoski and Brittany Barker found that people who use drugs reported a limited number of willing prescribers, as well as prescribers with long waitlists or who suddenly stopped prescribing safer supply. Several submissions singled out physician reluctance as a significant issue. Dan's Legacy and Moms Stop the Harm explained that some health care professionals are concerned that providing safer supply could subject them to scrutiny by the health care professional regulatory colleges or be a liability from an insurance standpoint. Dr. Mark Tyndall observed that there are some physicians that are not willing to accommodate people who do not adhere to strict rules, or who do not believe that addiction medicine should be part of their practice.

The College of Physicians and Surgeons of BC suggested that the media has erroneously criticized it for being a barrier to the implementation of the PSS policy and noted that it does not prevent physicians from prescribing safer supply if it falls within their scope of practice and they have the appropriate training and expertise. In addition, the College noted that the current fee-for-service payment model does not support family physicians prescribing safer supply, and that ideally multidisciplinary teams of health care workers would be involved. Doctors of BC shared that physicians need proper training and resources to be able to participate in prescribing a safer supply of substances and recommended that the government expand engagement with the organization as it further develops the PSS policy. The BC College of Family Physicians also suggested that education is paramount to increasing prescribers.

The BC Pharmacy Association stated that community pharmacists can be key participants in an integrated care model for providing a safer supply of substances where patients have access to both a prescribing physician and a community pharmacist. However, the Association also believes that considerable work needs to be done to create a treatment protocol and clinical guidelines that can be understood and implemented by prescribers and pharmacists for their patients receiving a prescribed safer supply of substances, and noted the current guidelines for dispensing these substances are inadequate and leave pharmacists in a position where they are vulnerable to scrutiny by the College of Pharmacists of BC.

Several organizations and individuals noted that it continues to be difficult to access a prescribed safer supply of substances in many areas of the province. In particular, organizations such as the Coalition of Substance Users of the North stated that a prescribed safer supply of substances is unavailable in nearly all rural and remote parts of the province. The Professionals for Ethical Engagement of Peers told the Committee these communities are "way behind" in terms of access to a prescribed safer supply of substances and suggested that the government could be doing much more to expand access including through telehealth. Long distances and insufficient transportation to receive a prescription or to pick-up and take doses was also identified as a key barrier for individuals in rural and remote areas, with the Rural Empowered Drug Users Network noting limited hours and locations for service providers, and the Coalition of Substance Users of the North suggesting that a delivery service could be a solution. It was also noted that existing programs that provide a prescribed safer supply of substances, such as the federally funded SAFER programs, are often at full capacity and not taking on more clients.

Several organizations and individuals pointed to requirements such as the need to pick-up prescribed substances each day and to have doses monitored, as well as mandatory urine drug screening, as presenting barriers. Guy Felicella, Moms Stop the Harm, the Substance Use Support and Employment Program, and others shared that these requirements make it difficult for people who use drugs to go about their daily lives and to engage in work or maintain housing. Similarly, the BC Centre for Disease Control stated that the requirement for one-to-one oversight and prescriptions from health care professionals excludes those who do not access health care or who do not want a record of their substance use.

Others noted the challenge for a prescribed safer supply of substances to compete with substances that can be purchased on the street, in terms of availability and effectiveness. Benjamin Perrin stated that a prescribed safer supply of substances needs to be as easy or, ideally, easier to get than the illicit substances an individual would otherwise use. Corey Ranger and others noted the importance of a prescribed safer supply of substances being available and prescribed in doses strong enough to compare to illicit drugs and to prevent withdrawal symptoms,

which are extremely unpleasant and can be life-threatening. Particular concerns were raised about the effectiveness and tolerance of hydromorphone (Dilaudid), a commonly prescribed pharmaceutical alternative to illicit opioids. Others pointed to the growing preference for inhalation as a method of consuming substances and noted that there needs to be a safer supply of substances that can be inhaled.

Another concern expressed to the Committee was that the PSS policy is not appropriate for many people, including occasional substance users and others who are not inclined to approach a medical professional to receive a prescription, often due to stigma. In this regard, the Vancouver Coastal Health Authority suggested there is a need to consider a safer supply of substances for the broader group of people at risk, including those who use stimulants or who may only use substances occasionally. Similarly, the Rural Empowered Drug Users Network shared its concern that it is nearly impossible for people who do not meet the criteria for a substance use disorder diagnosis to receive a prescription under the PSS policy, making many people vulnerable to the toxic drug supply.

Other organizations pointed out systemic barriers in the health care system that are preventing individuals from seeking a prescribed safer supply of substances. The PACE Society suggested that discomfort and a lack of training among prescribers is a hinderance to seeking a safer supply of substances. Drs. Karen Urbanoski and Brittany Barker found that stigma, racism, and discrimination made it more difficult for people to seek a prescribed safer supply of substances, while the John Howard Society of BC noted that many people who use drugs have experienced previous harms in their interactions with the health care system, including feeling unseen, invisible, or denigrated, and not receiving the help they needed. The AESHA (An Evaluation of Sex Workers' Health Access) Project noted the particular distrust of the health care system among many sex workers who use drugs.

The Committee heard about a few pilot projects seeking to address some of the barriers currently associated with the PSS policy. AVI Health and Community Services explained that the Victoria SAFER initiative, which is funded by Health Canada, provides a flexible model by offering a range of pharmaceutical alternatives, including fentanyl products, and is delivered with the support of a multidisciplinary team of health care and social services workers. Similarly, PHS Community Services Society provided details about its Fentanyl Powder Program, in which health care workers work with patients to determine doses that avoid withdrawal symptoms, and noted that patients of the program report it is working well to replace street-supplied fentanyl. PHS Community Services Society also noted it has started an enhanced access program that allows patients to purchase a take-home prescribed safer supply of substances and doesn't require a substance use disorder diagnosis. Dr. Mark Tyndall suggested vending machines in supportive housing units can provide a low-barrier option for picking up a prescribed safer supply of substances, such as the "MySafe" program he created. Once a person receives a prescription and enrolls in the program, they can pick up their daily dose from the machines using biometrics.

> *I'm hoping that as more education is provided for care providers, it will lower stigma, and that as people are accessing safe, regulated supplies rather than illicit supplies, it becomes recognized that we are really taking medicine. That's what it is to me. It's medicine that helps me be stable and well and whole.*
> (Hawkfeather Peterson, Parents Advocating Collectively for Kin)

The Committee heard some concerns related to the current PSS policy, mostly related to the risk of prescribed pharmaceutical alternatives being sold or given to others, which is often referred to as diversion. The College of Pharmacists of BC noted that the prescribed substances have the potential to cause significant harm. In this respect, measures such as daily pick-up and witnessed doses were seen as necessary safeguards. Others noted that patients who are prescribed a safer supply of substances need to be provided with a variety of wraparound supports to help stabilize their lives. The Pacifica Housing Advisory Association shared that those residing in supportive housing complexes, which typically have health care professionals on site, are more

successful in continuing to use a prescribed safer supply of substances because it is convenient to pick up and consume witnessed doses. A few organizations highlighted the need for careful evaluation of the PSS policy.

Non-Prescriber Models

Several organizations and individuals suggested that models to provide a safer supply of substances that do not require a prescription could help to overcome many of the barriers experienced under the current PSS policy. For example, the Northern Health Authority shared that it currently has only approximately 20 health professionals who can prescribe a safer supply of substances, and that there is limited access to pharmacies for picking up doses in the north. The Northern Health Authority, the Vancouver Coastal Health Authority, and the Provincial Health Services Authority all suggested that non-prescriber models are critical in addressing the shortage of prescribers. The BC Centre for Disease Control also stated the scale of the drug toxicity and overdose crisis is well beyond the capacity of the current prescriber-based model.

These organizations and others pointed to co-op or compassion club models as a possible solution, in which groups of people who use drugs collectively source and pay for a safer supply of substances to be used by their members. However, it was noted that such models would require the federal government to issue an exemption from the federal *Controlled Drugs and Substances Act*. The BC Centre on Substance Use noted that low-barrier access and sliding-scale fees encourage economic participation in comparison to receiving a free supply of substances under the PSS policy. Others, such as the Professionals for Ethical Engagement of Peers and People with Lived and Living Experience Committee noted that these models give people who use drugs agency in protecting their health and safety. The Cool Aid Society also noted that such models can be run by community groups and harm reduction organizations, which can allow prescribers such as physicians and nurse practitioners to focus on other harm reduction and treatment services.

Committee Discussion

The Committee recognized that providing a prescribed safer supply of substances is a necessary and important action in the context of the toxic drug supply, and as part of the substance use continuum of care. Members agreed that a prescribed safer supply of substances is the most immediate step that can be taken to prevent deaths and reflected on what they heard about the need for individuals to find safety and stability through a prescribed safer supply of substances prior to deciding to undertake treatment. The Committee was particularly struck by stories about individuals who had received a prescribed safer supply of substances and acknowledged the stabilizing effect upon their lives, since they no longer had to spend their days focused on finding substances to prevent debilitating withdrawal symptoms. Members felt strongly that if more British Columbians heard stories like these, it would help to build support for a compassionate response that includes providing a prescribed safer supply of substances.

The Committee supports the province's policy direction on Prescribed Safer Supply (PSS policy), as part of the substance use continuum of care. Members acknowledged that there has been some progress and pointed to the growth in the number of prescribers, as well as the growing number of clinic-based programs. At the same time, they discussed the newness of this policy and recognized that monitoring and evaluation is currently underway and will provide crucial insights about its effectiveness, the need for improvements, and any unintended consequences. As such, some Members noted that public reporting on these findings will be very important.

The Committee reflected on what it heard from the many organizations and individuals, including people with lived and living experience, about the barriers related to the PSS policy, and agreed that action should be taken immediately to address these barriers in order to reduce the number of people who are dying. Most importantly, Members agreed that there is a need for equitable access to a prescribed safer supply of substances throughout the province. They noted that a key impediment to this is a hesitancy from some potential prescribers to consider prescribing a safer supply of substances to their patients.

Members had a robust discussion about how to engage more potential prescribers in prescribing a safer supply of substances. They noted that improving addiction medicine education for all new and existing health care workers could be helpful. They added that continuing to build an evidence base and to develop additional clinical protocols and guidelines, in consultation with prescribers, would help to address some of the outstanding concerns about the PSS policy. Members noted that the BC Centre on Substance Use is well-positioned and should be supported to continue this work.

The Committee was struck by what it heard from some submissions about the role of the health profession's regulatory colleges, and particularly the College of Physicians and Surgeons of BC, in causing anxiety amongst some potential prescribers who feared additional scrutiny if they were to engage in prescribing a safer supply of substances. Members acknowledged that it was difficult to reconcile this with the position of the regulatory colleges that they are not presenting barriers for their registrants and agreed that given the role the regulatory colleges play in the provision of health care in the province, they must further engage in developing solutions to the drug toxicity and overdose crisis. Overall, Members felt that in the face of the health emergency, there is an immediate need for the regulatory colleges and related professional associations to come together to proactively address any remaining barriers to increasing the number of health care professionals prescribing a safer supply of substances.

The Committee reflected on the concerns it heard about many of the barriers related to accessing a prescribed safer supply of substances, such as the need to pick-up prescribed substances each day and to have doses monitored, as well as mandatory urine drug screening. Members acknowledged the reasons for some of these safeguards, such as preventing prescribed substances from being sold or given to others. However, they also noted that the same measures are not in place for other prescription drugs and questioned the role of stigma in some of the current requirements. The Committee recognized that the need for most individuals to have a substance use disorder diagnosis to obtain a prescription excludes people who may benefit from receiving a safer supply of substances, such as individuals who use drugs recreationally. Members acknowledged the specific barriers facing individuals living in rural and remote areas, including transportation to receive prescriptions and pick-up and take prescribed substances.

Overall, Members suggested the approach to prescribing a safer supply of substances should be guided by dignity, and that individuals who have chosen to seek safety and stability under the PSS policy should not face additional barriers to receiving care. Members agreed there should be consideration given to ensuring the availability of a safer supply of substances that adequately replaces the street supply in terms of dose and effectiveness, given the need to prevent debilitating withdrawal symptoms. There should also be a safer supply of substances that can be smoked given that more people are inhaling their substances.

When it came to considering alternative models to providing a safer supply of substances, such as non-prescriber models, the Committee engaged in considerable debate. There was broad recognition of the need to scale up the current approach to providing a safer supply of substances. Members acknowledged that the current PSS policy does not provide protection for all populations, notably people who are not inclined to seek care through a health care professional, but that these individuals remain at high risk from the toxic drug supply. At the same time, Members recognized the newness of the current approach and the need for continued assessment and evaluation, and grappled with their concerns about unintended consequences resulting from the rapid implementation of alternative models. Members took note of the need for the federal government to issue an exemption under the federal *Controlled Drugs and Substances Act* to implement a non-prescriber model. They felt that, for now, a connection with a health care professional—as is required under the PSS policy—remains an important safeguard but that there should be consideration given to alternative models that may address the findings of the early evaluations and planned expansion of the PSS policy.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

11. Fund measures to ensure a prescribed safer supply of substances is available in all areas of the province, including by:
    a. urgently engaging with the regulatory colleges and professional associations of physicians, nurse practitioners, nurses, and pharmacists in BC to identify and resolve barriers to prescribing and providing a prescribed safer supply of substances;
    b. increasing education and ensuring clear clinical guidance is in place for prescribers; and
    c. addressing barriers, such as transportation, for individuals in rural and remote communities.

12. Review the policy direction on Prescribed Safer Supply and current and future clinical guidelines to limit restrictive barriers and to allow for a range of prescribed pharmaceutical alternatives to be provided, including options for inhalation.

13. As part of the ongoing evaluation of providing a prescribed safer supply of substances, work with the federal government to consider whether alternative models should be trialed or implemented in order to scale up the response.

Treatment and Recovery

What the Committee Heard

Improving Treatment and Recovery Services

One of the major themes that was highlighted by multiple stakeholders, including the Union of British Columbia Municipalities, the BC Nurses' Union, and the Overdose Prevention Society, among others, was the need to improve access to treatment and recovery services, including detox or supported withdrawal. Many presentations and submissions to the Committee indicated that there are long waitlists for various treatment options, and emphasized the importance of immediately providing these services when a person is ready to receive them, referring to this time as a "window of opportunity." Committee Members received several recommendations related to increasing access to treatment and recovery services in rural and remote communities throughout the province. These included requests for more services outside of urban centres, such as northern communities where residents may have to travel long distances in inclement weather to access services.

The Committee also received input representing various viewpoints on abstinence-based treatment models. Some stakeholders felt that abstinence should be the ultimate goal for individuals seeking treatment for substance use. Others cautioned that abstinence-based programs can be dangerous for individuals who relapse after treatment because their tolerance has declined, making them more susceptible to overdose. Dr. Bonnie Henry, Provincial Health Officer, noted that abstinence-based treatment models were developed for individuals with alcoholism and that this model does not work for those with opioid addiction as it is a chronic relapsing brain disease. The Port Alberni Community Action Team and Corey Ranger identified abstinence requirements as a roadblock for some to access treatment and recovery services, as not all individuals seeking treatment might be able or prepared to undertake an abstinence-based approach.

A number of organizations and individuals expressed concerns about individuals who may lose income assistance while accessing treatment options. The Elizabeth Fry Society of Greater Vancouver recommended that income assistance should continue while an individual receives treatment for substance use to ensure that they can maintain their housing. The Committee also received a number of recommendations from various organizations, including the Office of the Representative for Children and Youth, related to the need for family-based treatment and recovery programs or various supports needed to keep families together while a family member is going through treatment.

Students Overcoming Substance Use Disorder and Addictions noted that some individuals seeking permanent resident status may be afraid to seek treatment and recovery services as this would be reflected in their medical records which could negatively affect their immigration application. As such, they recommended that the BC government work with the federal government to make it clear that seeking treatment services will not jeopardize an individual's immigration status or path to permanent residency.

The Committee received some input on involuntary treatment, both in favour of and against it. A few stakeholders, such as the Association Advocating for Women and Community and Westminster House Society felt that involuntary treatment would be beneficial for some individuals might not otherwise seek treatment for substance use. Others not in favour of involuntary treatment, such as the BC Civil Liberties Association, questioned this from a human rights perspective. Some input, such as that received from Benjamin Perrin, noted that forced

abstinence could have deadly consequences when an individual is released from involuntary treatment, as their tolerance level to certain substances would be lowered, thus making them more susceptible to overdose.

Regulation of Treatment and Recovery Services

The Committee received input and recommendations regarding the regulation of treatment and recovery services, with some organizations and individuals expressing that there is not adequate oversight of these facilities. The BC Coroners Service noted that treatment and recovery centres are not sufficiently regulated and that there are no "definitions of success" or ways to measure how effective treatment and recovery centres are; they also highlighted a lack of public reporting leading to gaps in the data. The BC Coroners Service suggested that it would be useful for the BC Centre for Disease Control to follow people after treatment to gather data and suggested this could be accomplished by collecting Personal Health Numbers.

Health Canada noted that the 2021 federal budget provided $45 million to develop national mental health services standards in conjunction with the Standards Council of Canada as well as the provinces and territories. Once finalized, the standards will be available for voluntary implementation by stakeholders and health organizations with responsibility for mental health and substance use service delivery, along with guidance and resources to be developed by the Standards Council of Canada. Some organizations, such as the BC Coroners Service, the Drug Prevention Network of Canada, and Turning Point Recovery, recommended that new legislation be created to provide oversight of treatment and recovery centres specifically, rather than having them fall under the *Community Care and Assisted Living Act*. Others, such as Westminster House Society and Together We Can, suggested that better tools to track and evaluate the success of these facilities provincewide would be helpful.

The Ministry of Mental Health and Addictions noted it has implemented a number of initiatives to strengthen the quality of patient care in relation to treatment and recovery. The Assisted Living Regulation (2019) sets mandatory health and safety requirements for all registered assisted living and supportive recovery residences to ensure that staff have necessary skills, training, and qualifications; it also enables individuals and their families to make better-informed decisions about treatment options. The Provincial Standards for Registered Assisted Living Supportive Recovery Services (2021) provide additional guidance for delivering high-quality care based on available evidence. Health authorities must incorporate the standards into the contract language they use for agreements with non-governmental service delivery partners.

Opioid Agonist Treatment

Opioid Agonist Treatment (OAT) is the primary treatment for opioid addiction and research shows that retention on OAT, which can reduce symptoms of withdrawal and decrease dependence on opioids, is also protective against overdose death. Officials from the Ministry of Mental Health and Addictions noted that retention on OAT has steadily increased since 2016. To give a sense of the uptake of OAT in BC, they indicated that nearly 25,000 people received this treatment through 1,745 prescribers in March 2022 alone. The BC College of Nurses and Midwives told the Committee that BC is the only province in Canada that has (temporarily) authorized registered nurses and registered psychiatric nurses to prescribe OAT for the treatment of opioid addiction, a change that was implemented through a public health order issued by the Provincial Health Officer in September 2020, as part of efforts to combat the drug toxicity and overdose crisis.

The Committee received input from a significant number of organizations and individuals, including the BC Centre on Substance Use and the Provincial Health Services Authority, that spoke about the need to expand access to OAT throughout the province, particularly in rural and remote communities. Some submissions suggested that this could be accomplished through expanding the types of health care professionals, such as pharmacists, who can prescribe OAT after receiving the prerequisite training. In addition to a need for more OAT prescribers, the BC Association for People on Opiate Maintenance and others expressed concerns about regulatory barriers to accessing OAT for some individuals that should be examined, reduced, or eliminated, such as the need for urine tests, witnessing of doses, and transportation or delivery restrictions.

The Committee also heard about a number of other medications, such as injectable OAT and tablet injectable OAT, suboxone, and others, that have been used to expand the options for OAT to address the specific needs or preferences of people diagnosed with opioid addiction and keep them retained in treatment. Organizations such as Resident Doctors of BC, Nurse and Nurse Practitioners of BC, and Dr. Perry Kendall, former Provincial Health Officer, urged the Committee to recommend that access to these options be expanded to meet the specific needs of individuals for whom these medications are more effective.

Committee Discussion

Committee Members noted that input related to improving and expanding access to treatment and recovery services was a significant topic reflected in the submissions and presentations they received, and reflected on the tragedy that many individuals on waitlists die before being able to access services. The Committee discussed the need to provide treatment and recovery services expeditiously when an individual indicates they are ready to receive these services and that, as a result, there must be a substantial expansion of publicly funded and accredited treatment and recovery services to meet the needs of British Columbians. Committee Members underscored the need for better data and information on treatment and recovery services and noted that it is difficult to ascertain the magnitude of the issue around availability of these services without a centralized data collection and inventory system in place.

The Committee agreed that there is no "one size fits all" approach for treatment and recovery and these services need to be varied to suit individual preferences, with special consideration for trauma-informed and culturally sensitive services. In particular, Members noted that the standard 28-day timeframe for treatment and recovery may not be optimal for individuals who might require longer to stabilize themselves and to facilitate better long-term outcomes. The Committee noted that one model to consider is recovery communities, which allow individuals to receive treatment and recovery services in a residential setting for a longer period, gain skills useful for employment, and experience peer-to-peer supports in a safe and non-judgmental atmosphere.

The Committee discussed other barriers to accessing treatment and recovery services, including inequitable access, transportation needs, location, and cost. The lack of family-centred treatment and recovery options was another issue that was highlighted by Committee Members, who agreed that parents and caregivers need to be better supported to access treatment and recovery services to keep families together where possible.

The Committee agreed that there needs to be regulations that ensure the provision of evidence-based treatment and recovery services. In this regard, Committee Members agreed that the *Community Care and Assisted Living Act* is not sufficient, and that new legislation dedicated to oversight of treatment and recovery services is needed. The Committee indicated that there needs to be more robust evaluation of outcomes from these services to inform government funding decisions and to also provide this information publicly in an anonymous and disaggregated manner, to increase accountability and transparency for these services. This will also ensure that families and individuals can make informed choices about these services based on outcomes and data. The Committee noted the importance of protecting the personal information of individuals who have accessed treatment and recovery services and ensuring data collection is used to promote equity and prevent harm.

Committee Members noted what they heard about the effectiveness of OAT in improving the lives of those with opioid addictions and helping to prevent deaths, and agreed that there is an urgent need to increase the number of health care professionals who can prescribe and provide OAT to meet the current demand. Members suggested this is particularly important in rural, remote, and Indigenous communities. The Committee agreed there should be further engagement with the health care professional regulatory colleges and professional associations aimed at increasing the number of prescribers of OAT, similar to what they recommended to increase the number of prescribers for a safer supply of substances.

Committee Members recalled what they heard about barriers faced by individuals seeking OAT, including requirements such as the need to pick-up prescribed medications each day and to have doses monitored, mandatory urine drug screening, challenges in travelling long distances to pick-up prescriptions, and financial

barriers for some types of treatment. The Committee noted the gap between what it heard from people seeking treatment, and what the College of Pharmacists of BC said about there being no requirements for daily dispensing, and agreed that clinical guidelines and education programs should be reviewed to ensure that unnecessary barriers to OAT are eliminated. While Members felt strongly that barriers need to be addressed, they also noted that there still needs to be monitoring, evaluation, and tracking and reporting on OAT to understand its effectiveness and ensure patient safety.

The Committee agreed that the *Mental Health Act* is outdated and urgently requires a comprehensive review, given that providing substance use treatment for individuals is sometimes dependent on provisions within that Act. Members agreed that this is particularly timely given that the Special Committee on Reforming the Police Act made a similar recommendation earlier this year.

Committee Members expressed concerns regarding the information they received about individuals seeking permanent resident status in Canada, who were reluctant to seek treatment and recovery services out of fear that this information may have a negative impact on their immigration. They agreed that the provincial government should work with federal counterparts to ensure an individual's immigration status or application for permanent residency is not jeopardized if they access treatment and recovery services.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

14. Urgently fund a substantial increase in publicly funded, evidence-based, and accredited treatment and recovery beds and outpatient services, including managed withdrawal (detox) and aftercare supports, while ensuring a variety of treatment options to support individual and family needs.

15. Create new legislation to provide a statutory framework that encompasses all treatment and recovery services in British Columbia, along with appropriate regulations, standards, and protocols.

16. Create a provincial system to collect data from treatment and recovery services to increase oversight and determine effectiveness with clearly defined outcomes that can be evaluated and reported on publicly.

17. Fund measures to ensure opioid agonist treatment is available in all areas of the province, including by:
    a. urgently engaging with the regulatory colleges and professional associations of physicians, nurse practitioners, nurses, and pharmacists in BC to identify and resolve barriers to prescribing and providing opioid agonist treatment;
    b. increasing education and ensuring clear clinical guidance is in place for prescribers; and
    c. addressing barriers, such as transportation, for individuals in rural and remote communities.

18. Review the policy and clinical guidelines for providing opioid agonist treatment to limit restrictive barriers and to allow for a range of prescribed medications to be provided.

19. Within six months of this report's release, initiate a comprehensive review of the *Mental Health Act* that includes public input.

20. Work with the federal government to ensure that accessing treatment and recovery services will not jeopardize an individual's immigration status or application for permanent residency.

Enforcement and Decriminalization

What the Committee Heard

Enforcement

The Ministry of Public Safety and Solicitor General explained that while policing represents an important component of the province's broader strategy to combat the drug toxicity and overdose crisis, there is no quick fix to the distribution of toxic drugs and associated gang violence across the province. It noted that law enforcement in the province has been addressing the issues of drugs, money laundering, and firearm violence holistically, and added that there are approximately 188 criminal groups involved in BC's illicit drug markets with at least 57 percent of organized crime networks involved in one aspect of fentanyl production, distribution, and trafficking.

> *We are not of the belief that if we had 15 times the resources of law enforcement that we have today that we could solve the problem from a law enforcement perspective.* (Ministry of Public Safety and Solicitor General)

Dr. Jaime Arredondo Sanchez Lira noted that Vancouver was the first place in North America that adulteration of the drug supply with fentanyl was detected. Since that time, Vancouver has been a port of entry for many new drug trends. He added that while fentanyl used to be imported into the country from China or Mexico, it is now largely manufactured in BC and other parts of Canada. The BC Provincial Toxicology Centre explained that criminal organizations are developing domestically produced cheaper synthetic opioids, which are experimental and more concentrated. Several law enforcement agencies, initiatives, and programs are currently focused on targeting the trafficking of illicit drugs; however, the Ministry of Public Safety and Solicitor General acknowledged that enforcement efforts must be supported by comprehensive health and social services, including safer supply, counselling, treatment, and supportive housing. Similarly, the BC Association of Chiefs of Police recommended expanding access to low-barrier drug rehabilitation and treatment programs and improving access to low-barrier options to receive a safer supply of substances.

The Committee also heard about recent federal changes regarding drug possession and sentencing. Health Canada outlined that in 2017, the federal Parliament passed the *Good Samaritan Drug Overdose Act*, which provides some legal protection from possession-related offences for individuals seeking emergency help during an overdose. It added that the Department of Justice also funds drug treatment courts, which delay sentencing while an offender participates in a federal or provincial substance use treatment program.

A number of organizations referred to the current use of resources for policing drug use as ineffective at solving the drug toxicity and overdose crisis. The BC Civil Liberties Association suggested resources should be shifted to non-coercive, voluntary policies, programs, and services that protect and promote people's health and human rights. Several submissions to the Committee also called for reduced police presence when dealing with people who use drugs in non-violent circumstances, while others noted a need for more mental health and crisis intervention workers for individuals in mental distress or with addictions. The Overdose Prevention Society observed that most drug dealers with whom the organization interacts sell drugs to support their own use, while Benjamin Perrin noted that the majority of

trafficking convictions are against these types of dealers rather than criminal organizations. Perrin further suggested that when someone receives a drug-related conviction, many conditions routinely sought by Crown prosecutors—such as not possessing syringes—may undermine harm reduction practices, while requiring individuals with substance use disorders to maintain sobriety can be cruel.

Several organizations highlighted the impact of drug possession charges on individuals and suggested alternatives to the traditional justice system. The Cool Aid Society noted that engagement with the criminal justice system can increase the complexity of issues a person who uses drugs might face, such as disrupting relationships or presenting mental health or health care setbacks. Others highlighted the importance of a restorative justice approach, rather than traditional justice system approaches, while the Drug Prevention Network of Canada noted the need to expand the use of drug treatment courts to increase the number of people going to treatment rather than prisons.

The AESHA (An Evaluation of Sex Workers' Health Access) Project noted that sex workers have been especially impacted by the drug toxicity and overdose crisis due to intersecting vulnerabilities, including the criminalization of sex work and drug use. Regarding police interactions with sex workers, both the AESHA Project and the PACE Society described high levels of targeting, harassment, surveillance, and arrest, particularly of Indigenous sex workers. The organizations raised concerns about police searching and harassing sex workers and confiscating harm reduction equipment. The PACE Society further noted that current enforcement practices used against sex workers can make these workers less likely to report violence they may experience, due to mistrust of police.

A small number of submissions recommended increasing the resources available to law enforcement agencies, with some suggesting that there be stricter penalties for drug trafficking and others citing the need for increased border security to stop the importation of drugs. For example, the Drug Prevention Network of Canada stated that a lack of funding for drug enforcement over the past 20 years has led to an increase in the availability of drugs. Some individuals suggested that there should be increased enforcement directed towards people who use drugs, in particular to prevent drug-related crimes.

The Committee heard that criminalization of people who use drugs is ineffective in reducing the use and availability of drugs and has many negative impacts. Dr. Perry Kendall, former Provincial Health Officer, noted that the drug toxicity and overdose crisis demonstrates that the prohibition model does not work and drives people toward drugs that are easier to smuggle and more potent, while Dr. Mark Tyndall suggested criminalization creates violence and destroys communities. The Public Health Association of BC, the BC Coroners Service, and Drs. Karen Urbanoski and Brittany Barker similarly outlined that criminalization has negative impacts on the effectiveness of safer supply and harm reduction strategies. The BC Civil Liberties Association noted that criminalization has disproportionately impacted marginalized communities, while The Bridge Youth and Family Services raised concerns that criminalization exacerbates stigma, which compels people to use substances alone. The BC Humanist Association referred to the prohibition on drugs as outdated, and based on a European Protestant Christian morality, which views substance use as an inherent moral failing, coupled with anti-Asian racism.

Decriminalization

Multiple organizations suggested that decriminalizing drugs would improve health outcomes by mitigating harms of the toxic drug supply while providing new opportunities for people who use drugs to connect with evidence-based health and treatment services. Peers Victoria outlined that decriminalization would improve the safety of harm reduction services offered by community-led groups, comprised of people who have used or currently use drugs, adding that responding to an overdose and speaking to police while carrying illicit drugs may currently place peer support workers at risk of arrest.

Officials from the federal government noted that the Public Prosecution Service of Canada implemented a directive in 2020 in which it would not accept criminal charges for personal possession offences unless there was conduct that posed a risk to the safety or well-being of children and youth or the person was in a position of trust or authority with respect to children or young persons. In addition, the Minister of Justice and Attorney General of Canada re-introduced legislative amendments in 2021 that would encourage diversion measures for personal drug possession offences rather than criminal charges and

repeal mandatory minimum penalties for six offences under the federal *Controlled Drugs and Substances Act*.

In May 2022, the federal government announced its intention to grant BC a three-year exemption under the federal *Controlled Drugs and Substances Act* to remove criminal penalties for people who possess a small amount of certain illicit substances for personal use, effective January 31, 2023. To support this exemption, the federal Minister of Mental Health and Addictions and Associate Minister of Health sent a Letter of Requirements to BC's Minister of Mental Health and Addictions, outlining actions that must be taken by the provincial government. Once decriminalization is implemented, adults carrying 2.5 grams or less of specific drugs, including cocaine, methamphetamine, or opioids, will not be charged, arrested, or have their drugs seized in most situations.

Prior to the federal announcement, the Ministry of Public Safety and Solicitor General explained that it continues to work with partners at all levels in support of decriminalization. The BC Association of Chiefs of Police noted that from its perspective, there has been de facto decriminalization for people who possess small amounts of illicit substances for the last three years. The Association stated it will continue to advocate for an integrated approach to divert people who use drugs away from the criminal justice system.

Very few concerns about decriminalization were raised by those who engaged with the Committee. While supporting decriminalization efforts overall, the Association of Chiefs of Police noted liability issues related to leaving people with known toxic drugs. The Orchard Recovery Centre expressed concerns that decriminalization and safer supply are normalizing drug use, which can create additional challenges for people that are in recovery or for people who are asking for help. Dr. Jaime Arredondo Sanchez Lira noted the importance of police training on the policies and regulations associated with decriminalization. He explained that drug enforcement in Mexico remained largely unchanged following decriminalization in 2009 because officers were unfamiliar with the threshold limits.

Other concerns related to the need for additional supports to accompany the implementation of decriminalization, such as referrals to treatment and other social services. In this regard, several individuals and organizations pointed favourably to the implementation of decriminalization in Portugal in 2001. The Portuguese Health Ministry explained that the Portuguese drug policy is a coordinated public health-oriented approach based on prevention, treatment, dissuasion, harm reduction, and reintegration. It added that the "dissuasion model" means those who are caught with a personal supply receive a police report but are also required to go before the Commission for Dissuasion of Drug Addiction, which is a multidisciplinary team that makes a treatment plan and provides support to the individual as they carry out the recommended plan. Portugal's public treatment network includes a variety of treatment options and harm reduction initiatives. According to Portuguese officials, fentanyl had not yet been detected in the country's drug supply.

Several organizations and individuals suggested that the threshold of 2.5 grams set by the federal government for the exemption under the federal *Controlled Drugs and Substances Act* is too low to be effective and noted the need to increase the amount. Some groups noted drugs are not regularly sold in units of 2.5 grams and added that individuals normally carry larger volumes, while Nurses and Nurse Practitioners of BC raised concerns that individual tolerance to substances may require people to carry more than 2.5 grams for personal use to prevent withdrawal symptoms. Further, Dr. Perry Kendall mentioned that Portugal's threshold is significantly higher than 2.5 grams, allowing individuals to carry one week's worth of drugs. Additional concerns were raised that the perspectives of people with lived and living experience were not adequately considered in determining the threshold amount, and that the input of law enforcement agencies was prioritized over the views of people who use drugs. The Rural Empowered Drug Users Network raised concerns that the threshold of 2.5 grams creates a two-tier model of decriminalization, wherein those who use lower amounts of substances, or have a permanent address at which to store their drugs remain free from harassment by law enforcement, but those who use higher amounts of substances or are experiencing homelessness remain criminalized. It added that the result is that the proposed model will do little for those most at risk of the harms associated with substance use and criminalization.

Several organizations outlined that threshold limits are especially problematic for rural communities, noting that, due to limited availability in rural regions, many people who use drugs regularly purchase and hold larger quantities. The Rural Empowered Drug Users Network conducted an informal survey amongst some of its members and found that several of the respondents who use fentanyl and methamphetamine regularly purchase more than 2.5 grams, some consume more than this amount in a single day, and many travel more than 50 kilometers to purchase drugs for themselves and others. Representatives from the Professionals for Ethical Engagement of Peers and People with Lived and Living Experience Committee also shared their experiences that police in rural communities still confiscate drugs despite police in more urban communities implementing de facto decriminalization, and expressed concerns that the threshold of 2.5 grams might increase the frequency of police profiling and use of the low threshold to target known users.

Committee Discussion

The Committee agreed that enforcement must be part of the broader response to the ongoing drug toxicity and overdose crisis, with a focus on organized crime. In particular, Members recalled what they heard about the majority of trafficking convictions being against individuals selling drugs to support their own use, and some Members supported efforts to move away from this type of enforcement. Further, Members recognized that efforts to disrupt the illicit drug supply and cut off criminal organizations from this revenue stream need to happen in tandem with emergency efforts to provide a safer supply of substances.

Members recalled that rather than calling for more dedicated funding for law enforcement, the BC Association of Chiefs of Police recommended expanding access to programs providing a safer supply of substances and to treatment and recovery services. Members agreed that police are already over-burdened in responding to overdose and mental health calls, for which they do not always have expertise, and it would be desirable to redirect these calls to more specialized responders. Further, they discussed the practice of a "warm handoff" from police or other first responders to the appropriate services or supports to ensure individuals receive the care they need. To this end, the Committee supported the recommendations made by the Special Committee on Reforming the Police Act, which focus on ensuring appropriate first response through increased coordination and integration across police, health, mental health, and social services, along with additional funding for health and social services.

Members were struck by the presentation by the BC Provincial Toxicology Centre, which noted that, to lower costs, criminal organizations are developing cheaper and more potent synthetic opioids, and often experimenting with these untested drugs on an unsuspecting public. Members agreed that the profits made by these organizations have resulted in the exploitation and suffering of many people, especially racialized and marginalized individuals. Further, these organizations have contributed to Vancouver becoming one of the largest trafficking ports for drugs on the continent. While Members noted the Committee did not receive any recommendations related to combatting organized crime, they agreed that this work is essential to disrupting illicit toxic drug supplies. In this regard, they noted the Ministry of Public Safety and Solicitor General is developing a BC Organized Crime Strategy.

In discussing concerns related to the threshold of 2.5 grams, Committee Members recognized that the province's request was for a 4.5-gram threshold, but that the threshold of 2.5 grams will be the reality given the exemption granted by the federal government. Despite the lower threshold, this exemption still represents a significant change to drug enforcement in the province, and Members expressed that it will be important to see the impacts of this policy. As BC is the first Canadian jurisdiction to implement decriminalization, the Committee agreed that these changes will need to be carefully monitored and evaluated, and that understanding the implications based on real-time data analysis and feedback will be an important guide for future decision-making.

Members further highlighted the need to listen to people with lived and living experience, particularly people living in rural and remote areas, Indigenous people, and racialized individuals, following implementation of the new policy to ensure that it is reducing the harms of criminalization, including the risk of death, and does not have unintended consequences. They noted that people who use drugs are not often meaningfully engaged or consulted in the development of drug policies, despite the significant impacts such policies have on these individuals. Members stressed that the voices of those most impacted by decriminalization, especially people who use drugs and

racialized individuals, must be heard throughout the process of implementation and evaluation.

Members recognized that there are very few jurisdictions around the world that have decriminalized drugs, and BC's approach speaks to the severity of the problem that is felt in every community across the province. They agreed that there must be consideration of local needs and circumstances during the implementation of decriminalization. In this regard, Members supported continued consultation and support for municipalities, including through the working group that the Ministry of Mental Health and Addictions and Union of BC Municipalities have established, which has the goals of ensuring that local governments are able to provide feedback regarding planning efforts and are able to identify local strategies to help make decriminalization effective in achieving intended outcomes.

The Committee discussed the Letter of Requirements to support BC's exemption under the federal *Controlled Drugs and Substances Act*, which outlines details further to the commitments made by the province to support the successful implementation of the exemption. These include actions related to improving access to health services; providing law enforcement training and guidance; undertaking meaningful engagement with Indigenous peoples; undertaking continued consultation with people who use drugs, law enforcement, racialized communities, and other key stakeholders; leading effective public awareness and communications; and conducting comprehensive monitoring and evaluation. Committee Members recognized that there is preliminary work that must be done to support the implementation of decriminalization as outlined in the letter, particularly with respect to consultation and to improving access to health services.

Members reflected on the volume of public input received through the Committee's consultation which noted extended wait times and a lack of resources for treatment and recovery services. They underscored the urgent need for additional, well-funded services and resources across the province to allow police to refer individuals who are not being charged to substance use supports and services. As such, Members agreed that additional funding from the federal government is needed to improve access to health services in BC.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

21. Prioritize the modernization of policing in BC, as outlined in the recommendations made by the Special Committee on Reforming the Police Act, with particular attention paid to altering the role of police in responding to complex social and health matters and investing in health and social services.

22. Work with the federal government and port authorities to develop innovative solutions to disrupt the supply of illicit toxic drugs being imported and produced domestically by international and domestic criminal organizations.

23. Work with the federal government, in continued meaningful consultation with people who use drugs, law enforcement, Indigenous peoples, racialized communities, and other key stakeholders, to collect data to measure and evaluate:
    a. whether decriminalization at the approved threshold of 2.5 grams is effective in reducing the harms of criminalization, and
    b. whether the effects of decriminalization have any unintended consequences.

24. To support the successful implementation of decriminalization, advocate for an increase in funding from the federal government to ensure that there is sufficient capacity for police to refer individuals who are not charged to substance use supports and services.

Indigenous People

What the Committee Heard

Decolonization

Many organizations highlighted the disproportionate number of Indigenous people, especially women, impacted by the crisis, and called for a decolonized approach to drug policy. The Ministry of Mental Health and Addictions stated that in 2021, First Nations people died from overdoses at 5.4 times the rate of other BC residents and First Nations women died at 9.8 times the rate of other women in BC. The Committee heard that many factors contribute to this disproportionate impact on Indigenous people. Dr. Nel Wieman, Deputy Chief Medical Officer with the First Nations Health Authority, stated that the root causes for this overrepresentation are complex and varied, but they are grounded in colonialism and racism including the effects of intergenerational trauma due to residential schools, the Sixties Scoop, and ongoing child apprehensions.

The First Nations Leadership Council noted that for many Indigenous people, substance use is deeply linked to the legacy and ongoing impacts of colonialism. It indicated that many Indigenous people continue to process intergenerational trauma that has its roots in displacement from and theft of their lands, the removal of their children through the residential school and child welfare systems, and state control over their decisions and their bodies through institutional mechanisms like the *Indian Act*. Further, the Native Women's Association of Canada asserted that intergenerational trauma increases the risk of poverty, crime, gender-based violence, addiction, generational breakdown, family violence, parental neglect, and toxic family environments. The Tsow-Tun Le Lum Society noted that many Indigenous people feel disconnected from culture and community as a result of the intergenerational effects of colonialism.

The Committee also heard about the significant barriers that exist for Indigenous people to access services and supports across health care, housing, and social services due to discrimination, racism, and stigma within these systems. The Kílala Lelum Health Centre expressed the need to address the disproportionate impact of illicit drug toxicity deaths among Indigenous people by decolonizing the health care system, noting that this decolonization should include implementing the Truth and Reconciliation Commission's calls to action related to health care, as well as including respectful sharing of cultural approaches to illness, health, and wellbeing, including connections with Elders. Similarly, Indigenous Child and Family Services Directors stated that all practice, policy, and legislation must emerge from a place of understanding, recognition, and respect for Indigenous rights and ways of being to address racism in both the health care and child and family services systems and ensure these systems contribute to wellness rather than to trauma. The First Nations Leadership Council advocated for the development of a culturally appropriate and trauma-informed substance use continuum of care through meaningful consultation with Indigenous people. The Council also stressed the need to provide funding to build capacity at a community level to create customized services and supports for Indigenous people with input from them directly, including those with lived and living experience.

With respect to policy development, Grand Chief Doug Kelly of the Sto:lo Tribal Council stated that current drug policies need to be decolonized, which demands an Indigenous framework and centering of Indigenous cultures, values, philosophies, and knowledge, as well as self-determination. Métis Nation BC told Committee Members about the particular challenges facing its community members and that it is important for Métis people in BC to be included in policy development and the design of services and supports. It further noted that often there is a pan-

Indigenous approach to engagement taken, which treats the three distinct Indigenous groups across Canada as though they are one body and does not recognize different cultural practices and histories of unique groups. It emphasized the need for a distinctions-based approach in examining and responding to the drug toxicity and overdose crisis.

Prevention and Education

With respect to prevention, the Committee heard that there is a continued need to recognize and build awareness of the widespread impact of the historic and ongoing traumas of colonialism, racism, and residential schools. Indigenous Child and Family Services Directors called for investments in needs-based, wraparound prevention services and resources that focus on a culture-centred approach and include Indigenous perspectives. Further, Carrier Sekani Family Services stated that prevention services need to be decentralized and accessible to First Nations communities.

The Committee also heard about the need for culturally appropriate and informed mental health services and supports for Indigenous people. Indigenous Child and Family Services Directors stated that there is a need to reform funding models and outcome measures with respect to mental health and wellbeing services, as the current system has failed to meet the basic needs of Indigenous children, youth, and families. Grand Chief Kelly suggested that funding for prevention initiatives should be prioritized, starting with childhood services that support children and their families with their mental health from trauma-informed, Indigenous perspectives. The Committee also heard the need for Indigenous-specific supports, including affordable housing and social supports to improve social determinants of health.

Harm Reduction and Safer Supply

The First Nations Health Authority and others noted the lack of harm reduction services available to Indigenous people living in rural and remote areas of the province. The BC First Nations Justice Council suggested the disproportionate impact of the drug toxicity and overdose crisis for northern BC could be due to the current fragmentation of social services available to people who use drugs across the province, noting that it is difficult for social service agencies to recruit and retain professionals due to burnout and low pay. The Council further noted that in some agencies, staff lack the proper training to work with Indigenous people in a trauma-informed way. The Native Women's Association of Canada added that Indigenous women, girls, two-spirit, transgender, and gender-diverse people face further barriers when accessing harm reduction services, including sexism, violence, lack of childcare, and the threat of having their child apprehended.

As a result, it was suggested to the Committee that there needs to be an Indigenous-specific approach to providing harm reduction services. The BC First Nations Justice Council stated that this approach should focus on tackling the underlying systemic issues that perpetuate a cycle of harm, while the Pacific Association of First Nations Women shared that it should be shaped around Indigenous cultural wisdom and practices. The Committee also heard about some examples of Indigenous-specific harm reduction services, such as Raven's Eye Sage Sites, which are on-demand overdose prevention sites for First Nations people, as well as a new overdose prevention site being run by the Cheam First Nation in partnership with the First Nations Health Authority and the Fraser Health Authority.

The Committee heard about similar barriers with respect to access to a prescribed safer supply of substances for Indigenous people, particularly those living outside of urban centres. The First Nations Leadership Council stated that some people are excluded from the medical model of safer supply due to limited capacity, inflexible eligibility requirements, and immense persistent barriers to access. Dr. Nel Wieman, Deputy Chief Medical Officer with the First Nations Health Authority, noted that seeking a prescribed safer supply of substances can be a challenge for some Indigenous people because of known racism in the medical system and previous experiences with health care professionals, while the Native Women's Association of Canada added that a prescribed safer supply of substances needs to be administered in a low-barrier, Indigenous-women centred environment that is friendly and safe for two-spirit, transgender, and gender-diverse individuals.

Treatment and Recovery

Many organizations noted that there is a lack of culturally appropriate, trauma-informed, and safe options available for

Indigenous people who wish to access treatment and recovery centres or services. The First Nations Health Authority noted that jurisdictional divides can result in those in Indigenous communities not being able to fully access all of the services that are available in urban centres, and that significant gaps remain regarding access to timely and culturally appropriate treatment for Indigenous people. It also indicated that it does not have direct access to private treatment beds and told the Committee that some Indigenous communities are paying for this treatment out of their own budgets to fill this gap in service.

Indigenous Child and Family Services Directors indicated that current barriers to accessing treatment include: the lack of beds available, detox requirements, lack of extensive treatment to address complex behaviours, youth justice involvement limiting access to treatment centres, and the lack of funding and resourcing for culturally grounded treatment for Indigenous youth. The Committee also heard that accessing treatment and recovery services can be especially daunting for Indigenous parents and families as they can fear that entering treatment and recovery centres could result in their children being apprehended.

Enforcement and Decriminalization

A common theme heard by the Committee was the disproportionate impact of the criminalization of drugs on Indigenous people. Grand Chief Kelly suggested the need to implement a new drug policy that supports Indigenous peoples' rights, dignity, health, and wellness through decriminalization and the end of mass incarceration of Indigenous people who use drugs. Dr. Nel Wieman expressed concerns that the proposed 2.5 grams exemption under the federal *Controlled Drugs and Substances Act* is problematic and insufficient to reduce the harms and stigma of drug prohibition, especially for Indigenous people living in rural and remote communities.

With respect to the impact of enforcement of drug policy on Indigenous people, the BC First Nations Justice Council outlined that systemic racism is part of a continuation of colonialism that is being defended and perpetuated by police. Noting that this crisis cannot be addressed without a meaningful examination of the role police play in enforcement and criminalization of poverty and addictions, it called for a multidisciplinary approach to keep police out of contact with individuals experiencing substance use issues and highlighted the need for better police training. The Council further noted the negative impacts of incarceration on Indigenous people and pointed to the BC First Nations Justice Strategy, which focuses on transforming the existing system of justice and rebuilding Indigenous justice systems and institutions. An important principle of the strategy is the "presumption of diversion" whereby, for First Nations, all alternatives to the criminal justice system must be explored when appropriate.

Committee Discussion

Committee Members had an in-depth discussion about the disproportionate impact that the drug toxicity and overdose crisis is having on Indigenous people, especially Indigenous women, and the role that stigma and racism plays in contributing to this. Further, Members reflected on profound and ongoing impacts of colonialism, including the announcement by the Tk'emlúps te Secwe'pemc Nation that it had located the remains of 215 children in unmarked burial sites at the former Kamloops Indian Residential School last summer, and subsequent similar announcements in other parts of the province, which were particularly triggering for many Indigenous women and communities. Members agreed that it is important to adopt a decolonized approach to addressing the crisis that allows and encourages Indigenous people to develop solutions, programs, and services that meet the needs of their communities. Further, they discussed that within a decolonized lens, there are opportunities for Indigenous communities to provide services to neighbouring non-Indigenous communities as well. Recognizing the need for a distinctions-based approach, the Committee highlighted the need to ensure engagement with Métis organizations with respect to mental health and wellness for Métis people.

Improving access to services and supports for Indigenous people was a common theme in the Committee's discussions. Members reflected on many existing barriers to access for Indigenous people, including racism and stigma within the health care and social services systems as well as a lack of services and transportation in remote communities. Recognizing that Indigenous children have not had equitable access to services that other children in Canada have had, Members discussed the

importance of Jordan's Principle in ensuring immediate access to care and treatment. They emphasized that services spanning the substance use continuum of care must be accessible for Indigenous communities, both in terms of geographic location and in terms of being culturally appropriate and trauma informed.

Further, they noted it is important to partner with Indigenous leadership to provide these services. As such, Members recommend funding Indigenous-led and Indigenous-designed programs and services across the substance use continuum of care from prevention to treatment and recovery to improve access. As one example, Members recalled the presentation from the Tsow-Tun Le Lum Society and its desire for increased funding to expand services and build an additional building at the site of its new treatment centre in Cowichan. Increased services for Indigenous people in the provincial corrections system was also a topic of discussion, with Members agreeing on the need for more culturally appropriate, Indigenous-led services in this area. They discussed the importance of both the federal and provincial governments providing funding to help Indigenous communities respond to this crisis.

With respect to enforcement and decriminalization, the Committee recognized that Indigenous people are disproportionately criminalized for drug use and overrepresented in the criminal justice system. Members reflected on the importance of working with the BC First Nations Justice Council to implement the BC First Nations Justice Strategy to reduce the number of Indigenous people who become involved with the criminal justice system.

The Committee discussed the importance of implementing the recommendations to reduce stigma and racism as outlined in a number of key reports, including the Calls to Justice from the National Inquiry on Missing and Murdered Indigenous Women, the Calls to Action from the Truth and Reconciliation Commission, and the *In Plain Sight* and *Red Women Rising* reports. Members agreed that these reports and recommendations should guide the government's work in this area. In particular, Members highlighted recommendations 17 and 20 from the *In Plain Sight* report which call for culturally safe mental health and substance use services and mandatory training for health care workers.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

25. Fund Indigenous-led and Indigenous-designed, trauma-informed, and culturally appropriate services across the substance use continuum of care, including:
    a. prevention services that support children and their families with their mental health as well as children and youth who may be living with family members who use substances or struggle with addiction;
    b. harm reduction services, including those designed specifically to address the needs of Indigenous women, girls, two-spirit, transgender, and gender-diverse people;
    c. treatment and recovery programs, including in BC Corrections facilities; and
    d. mental health and social supports.

26. Prioritize engagement with the BC First Nations Justice Council to implement the BC First Nations Justice Strategy, including by transforming the criminal justice system, reducing the number of Indigenous people who become involved with the criminal justice system, and supporting Indigenous-led initiatives rooted in Indigenous culture and laws.

27. Use the recommendations from the *In Plain Sight* and *Red Women Rising* reports, the Calls for Justice from the National Inquiry on Missing and Murdered Indigenous Women, and the Calls to Action from the Truth and Reconciliation Commission as a guide for government action to reduce stigma and racism toward Indigenous people, especially Indigenous women.

Youth

What the Committee Heard

According to the BC Coroners Service, overdose is currently the primary cause of death for people aged 19 to 39 and the third most likely cause of death for those aged under 19 years of age. Further, the Office of the Representative for Children and Youth shared that in 2021, 30 people under the age of 19 died from a toxic drug overdose or poisoning in BC, which is the highest number on record and represents an over 200 percent increase over 2016 numbers. In addition, the Office noted that 324 people aged 19 to 29 died from toxic drug poisoning in 2021 which represents a 59 percent increase from 2016. Foundry BC described overdoses due to the toxic drug supply as an unprecedented youth health crisis.

Prevention and Education

The Committee heard support for more initiatives aimed at youth to prevent substance use, including education programs. Foundry BC expressed that there is a need to increase young people's awareness through balanced early education about substance use. A number of organizations highlighted successful school-based prevention and education programs, including Unplugged and PreVenture, while the Ministry of Mental Health and Addictions shared programs being used in BC schools, including ABCs of Substance Use and Mental Health in Schools.

Some organizations also expressed support for the Icelandic Prevention Model, which focuses on changing the social environment around children and youth and can lead to positive behaviour changes over time. For example, Iceland reported that, in their survey of 15- and 16-year-old students from 1998 to 2022, they had seen a dramatic decline in the proportion of students who had become drunk in the last 30 days (42 to five percent), smoked daily (23 to one percent), and have used cannabis (17 to seven percent). Planet Youth Lanark County shared its experience with the Icelandic model and stated that for this type of program to be implemented there needs to be strong provincial support and general community uptake, participation, and input into the design.

Committee Members heard from a number of organizations and individuals that substance use often serves a purpose in a young person's life, such as providing a coping mechanism to deal with unresolved childhood trauma, loss, or grief. The Office of the Representative for Children and Youth stressed the need to keep children and youth who use substances alive as the first priority, and then address the underlying causes for their substance use though improved services and supports for prevention and education. As such, the Office advocated for providing services and supports for children and youth earlier in life, rather than trying to address their substance use further down the line.

> *Oftentimes, something traumatic has happened. Then that sets things in motion that have the long-term impacts around numbing emotional pain, which is what young people tell us over and over again they use substances for. So, [we need to think] about those critical events and what is our intervention at those important developmental times, and also about how critical that eight, nine, 10, 11, 12 age is.* (Dr. Jennifer Charlesworth, Representative for Children and Youth)

The Committee heard that adverse childhood experiences are stressful, potentially traumatizing events that can arise in the household, community, or other environments and lead to well-documented health impacts, including an increased risk for substance use. In addition to working to prevent adverse childhood experiences, several organizations advocated for increased mental health supports for children and youth to address adverse childhood experiences. Drs. Cecilia Benoit and Andrea Mellor also noted that youth who are most marginalized due to their socioeconomic status, gender, sexual orientation, and racial background are at the greatest risk of experiencing substance use and/or mental health challenges and that youth-specific engagement for these young individuals is lacking.

Regarding support for children and youth, the Ministry of Children and Family Development acknowledged that the demand for mental health supports for youth is increasing. The Ministry noted that it is facing staffing challenges but that children and youth who have the most serious needs receive services right away, while those with more moderate or mild concerns may have to wait for some services. The Committee heard that children and youth face similar barriers to those of adults when trying to access mental health services, such as costs and waitlists. The Committee also heard about the importance of stable, secure housing for youth in preventing substance use, including the importance of having a stable home to return to after treatment.

The Ministry of Mental Health and Addictions outlined supports and services that are being implemented in a number of communities to promote resiliency for youth, including Integrated Child & Youth (ICY) Teams that work to connect young people to early integrated mental health and substance use care. The programs and services that ICY teams can connect young people with include early years supports and services, Indigenous-specific services and supports, primary care, community-based services and supports, Foundry centres, and virtual counselling through "Here2Talk" for post-secondary students.

Family Services of Greater Vancouver and Victoria Youth Clinic discussed the need for supports for children and youth in care or transitioning out of care, who may be at higher risk of using substances. The Ministry of Children and Family Development stated that it has implemented measures to reduce the risk of illicit drug fatalities for children and youth in care, including training for foster caregivers, a cross-disciplinary course for Ministry staff on substance use, and distribution of naloxone kits. The Committee also heard that it is important to work with youth directly to develop solutions and to provide a complex care model that includes skills development, trauma counselling, cultural supports, food security, and low-barrier housing.

Harm Reduction

The Office of the Representative for Children and Youth told the Committee that safe places for youth and young people to use drugs are required to keep them alive and that there is a need to dispel the myth that measures related to harm reduction encourage or condone substance use. In this regard, several organizations and individuals highlighted the lack of supervised consumption and overdose prevention sites designed specifically for youth, noting that programs and services designed for adults can be unsafe for young people, including by exposing them to exploitation. Providing safe spaces for youth was also identified as an important component of other harm reduction services, including drug checking. Covenant House Vancouver noted the importance of engaging with youth to co-create harm reduction services that foster a sense of belonging and are open beyond regular business hours to better serve youth and young adult populations.

Covenant House Vancouver stated there is a need to provide a safer supply of substances that is age-appropriate and works for young people. It indicated that there is currently no clear path for youth to receive a safer supply of substances, and also a lack of qualified medical professionals who are willing to provide prescriptions. A representative from the Professionals for Ethical Engagement of Peers noted that youth don't have access to a safer supply of substances, as they are often pushed towards going to treatment or recovery, even if they aren't ready for that, and it is very difficult to get a prescribed safer supply of substances independently without parental permission or especially for youth in care.

Treatment and Recovery

Input from some organizations, such as Covenant House Vancouver and the Victoria Youth Clinic, indicated that there

are not enough treatment and recovery services and supports created specifically for youth and that options created for adult populations may be too intimidating for youth to access or may not be appropriate for them. The Committee heard that some current policies, such as short time limits on residential treatment and recovery services, can result in youth being discharged before they are ready and without crucial supports in place, such as stable housing. As such, there needs to be more wraparound supports available for youth who receive treatment for substance use. Similarly, the Office of the Representative for Children and Youth noted that 28 days for treatment programs may not be long enough to effectively address substance use issues for youth or young adults with multiple challenges and recommended that the Committee consider increasing the length of treatment programs beyond this timeframe to increase effective outcomes.

Dr. Danya Fast shared with the Committee a recent report focused on youth voices on substance use treatment, including key recommendations and findings for care providers. A central theme was that young people need to be empowered with control or self-determination over their treatment trajectories and included in decision making to ensure better engagement and uptake. Another finding was that medicalized models of care or treatment can be triggering for some youth who have been institutionalized or who have had negative interactions with the health care system.

Including Youth

The Committee also heard about the importance of involving youth in designing appropriate and effective substance use services and supports. Family Services of Greater Vancouver indicated that there is a need to involve youth in building a substance use continuum of care that responds to their needs, closes the gap between shame and recovery, prevents exploitation, and engages youth wherever they are on their journey. Similarly, representatives from Professionals for Ethical Engagement of Peers and the People with Lived and Living Experience Committee shared that the perspectives of youth are often overlooked, and that their distrust in government or the health care system can prevent them from accessing life-saving harm reduction or treatment and recovery services. For this reason, they explained that youth need to be consulted on policies related to the drug toxicity and overdose crisis.

Committee Discussion

Committee Members reflected on the tragic impact of the drug toxicity and overdose crisis on youth, and agreed that this necessitates a distinct and urgent response tailored to the needs of children, youth, and young adults. The Committee recognized the long-term effects of childhood trauma and adverse childhood experiences, and how these can drive youth and young adults to use substances as a way to cope. With this in mind, Members agreed that interventions aimed at increasing resiliency and addressing the root causes of substance use for children, youth, and young adults are critical to the government's response.

Committee Members agreed on the need for initiatives to prevent substance use and education on the risks of substance use for children, youth, and young adults and were pleased to learn about various school-based prevention and education programs already in place, including PreVenture. However, the Committee wanted to ensure that any prevention and education materials are realistic about the risks of substance use in general, as well as the current toxic drug supply, to discourage use and also provide relevant information for children, youth, and young adults who may turn to substances regardless of warnings. The Committee noted the shortage of school counsellors and suggested that more specialized school counsellors could help students with mental health and substance use issues. In addition, the Committee highlighted the need for equitable access to prevention and education programs throughout the province, as well as measurable deliverables, oversight, and accountability to ensure that programs and services are meeting their desired objectives.

The Committee was pleased to hear about a number of initiatives integrating mental health and substance use care for youth, including Foundry and Foundry Virtual, which offers health and wellness services for youth and their families, including primary care, mental health and substance use services, peer support, and social services. The Committee was interested to hear about Integrated Child & Youth (ICY) Teams. While these are positive initiatives, Committee Members noted there is still a lack of

access to mental health and substance use supports for many children and youth due to regional disparities, financial barriers, and long waitlists to access professional services. The Committee agreed there should be affordable, accessible, trauma-informed mental health care, including trauma counselling, made available throughout the province for children, youth, and young adults dealing with trauma and adverse childhood experiences. Members agreed there should also be increased funding to identify children with neurodiverse needs, such as those with attention deficit hyperactivity disorder, which can lead to substance use without appropriate early interventions. In addition, and in recognition of the ongoing harms of the child welfare system, the Committee discussed the importance of returning child welfare jurisdiction to Indigenous communities and the need to prevent separation of children from parents.

Committee Members noted that adult-oriented substance use programs and services are often intimidating and unsafe for youth and young adults. As such, the Committee agreed there is a need for a customized substance use continuum of care developed specifically for youth and young adults and emphasized the need for services and supports to be safe and welcoming, as well as wraparound supports beyond health care, such as employment, housing, and counselling. Committee Members agreed that it is important to consider services and supports for youth who are transitioning to adulthood, and for youth transitioning out of care.

For youth and young adults at high risk of overdose from the toxic drug supply, the Committee acknowledged that a prescribed safer supply of substances can play a role in harm reduction as part of a robust continuum of care, to help prevent death. Committee Members agreed that care must be taken to ensure harm reduction efforts targeted to youth are not portrayed as potentially encouraging or condoning substance use but are viewed as life-saving emergency measures. The Committee wanted to ensure that any harm reduction services for youth and young adults are connected to options for treatment and recovery services and supports whenever possible.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

28. Urgently expand in-school prevention and education programs that include information on the risks of the toxic drug supply and are trauma-informed, evidence-based, and standardized.

29. Fund universal access to integrated mental health and substance use supports for children, youth, and young adults, including:
    a. increasing the number of specialized school counsellors;
    b. expanding Integrated Child & Youth (ICY) teams; and
    c. implementing targeted initiatives for children and youth in care.

30. Fund additional resources to provide timely evaluations of children for attention deficit hyperactivity disorder (ADHD) and other neurodiverse needs so that they can receive the support they need.

31. Fund and implement a robust substance use continuum of care developed specifically for youth and young adults that includes equitable and safe access to harm reduction, safer supply, and treatment and recovery services, as well as wraparound supports that include supportive housing.

Additional Measures

What the Committee Heard

Supporting Community Groups

Some organizations discussed the importance of community groups, such as non-profit organizations, in responding to the drug toxicity and overdose crisis, and advocated for increased funding and support for these groups. The Victoria Community Action Team shared that community groups are well placed to rapidly identify, interpret, and respond to community needs. The Committee also heard concerns about the funding structure for community groups. PAN explained that the current funding system is complex, and funding is insufficient and varies too much from one health authority to another. Further, AVI Health and Community Services stated that health authorities are legally required to provide funding under a procurement model which is restrictive and often short-term in nature meaning that community groups live with uncertainty.

Several organizations and individuals also outlined the important work being conducted by community-led groups, sometimes referred to as drug user groups, to respond to the crisis. Peers Victoria described the importance of peer support work, noting that several of its community outreach workers view the work as an opportunity to give back to the community, earn income, share their knowledge with other staff, and reduce stigma. The organization noted the importance of integrating peer programs into more support services for people who use drugs, as there is a wide variety of people who described first-hand experiences of poor treatment at hospitals and services that they regularly access.

The Rural Empowered Drug Users Network stated that community-led groups have been carrying a heavy burden in responding to the drug toxicity and overdose crisis, and as such, many of their members are depleted and exhausted. It noted that people who use drugs have been at the frontline of harm reduction work for years, often for free and without support. The Vancouver Area Network of Drug Users explained that they have been providing and advocating for necessary supports based on ground-level experience, sometimes by providing unsanctioned but essential harm reduction services. Some groups also noted that by being on the frontlines of the illicit drug toxicity and overdose crisis, they are better positioned to notice trends or patterns that can then be used to improve policies. However, the Committee heard that, like other groups, the work of community-led groups is hampered by a lack of sustainable funding, and that there is a need for improved funding and support from the government.

Supporting First Responders

A common theme to emerge during the Committee's examination was the critical role first responders play in responding to the crisis as well as the impact the crisis has had on these services. BC Emergency Health Services described the feeling of helplessness experienced by some of its paramedics, who attend to toxic drug-related events involving the same person repeatedly and witness them in a consistent state of suffering. First responders discussed areas where they could be of further assistance responding to the drug toxicity and overdose crisis, such as paramedics taking an enhanced role in rural communities, and allowing first responders to connect people who experienced a toxic drug-related event to outreach services. BC Emergency Health Services referred to the transport of a person following a toxic-drug related event as the "opportunity to break the cycle," as patients often get frustrated and leave the emergency department due to long wait times. Additionally, the BC Association of Chiefs of Police stated

there is a significant lack of immediately available substance use treatment services, which leads to the continued cycle of crime, criminal justice system involvement, and continuation of addictions. The Ambulance Paramedics and Emergency Dispatchers of BC discussed paramedics taking on an enhanced role in communities to help mitigate demand related to toxic drug-related events and help individuals navigate access to health care, especially in rural communities.

> *When people are revived, if they regain consciousness, 80 to 90 percent are not going to hospital. They're getting up, and they are walking away, and many times we are going back to them multiple times throughout the day.* (Karen Fry, Fire Chiefs' Association of BC)

Regarding emergency communications, E-Comm 911 noted the drug toxicity and overdose crisis is significantly adding to overall 911 call volumes and impacting services. The Committee heard that there is no legislation regulating 911 call answer standards or service levels and Emergency Communications Professionals of BC highlighted the need for oversight of 911 to ensure that the primary objective is prioritizing public health and safety. The Committee also heard that the next generation of 911 services, coming in December 2024, will provide more accessible services for people with disabilities by enabling people to text 911 directly and should improve services to rural, remote, and Indigenous communities. Organizations also noted that this new generation of 911 services could offer more community-based supports in addition to the main three options (police, fire, and ambulance).

The Crisis Intervention and Suicide Prevention Centre of BC stated that a crisis care continuum would provide alternate pathways to care for mental health and addictions through crisis lines, mobile crisis response teams, and crisis stabilization centres. This could reduce reliance on police, fire, and ambulance while providing coordinated, non-coercive, wraparound intervention and care for people in crisis. The Centre also stated the province needs to focus on embedding suicide prevention into its response to the drug toxicity and overdose crisis and mobilizing crisis lines to complement and strengthen the emergency crisis responder workforce.

Improving Health Care Delivery

Several organizations, including the Public Health Association of BC, highlighted the need for low-barrier and culturally appropriate access to primary health care, which needs to include wraparound supports. Resident Doctors of BC noted that clinical health care settings can be problematic, unwelcoming, or even triggering for some individuals who seek care for substance use, and added that anyone in the health care system can provide low-barrier compassionate care, not only physicians. The BC College of Family Physicians stated there is a need to increase cultural humility and anti-racism competencies in the provision of health care services, supports, and policies, further explaining that "culture heals" for many people, so there needs to be ongoing funding and support for culture-based programs.

A variety of organizations expressed concerns about stigma in BC's health care system. The Northern Health Authority noted that stigma is a barrier that can lead to poorer patient care and decrease the use of health care services, which contributes to higher mortality rates. Several organizations indicated that addressing stigma requires a paradigm shift and many made suggestions around how to decrease stigma in a medical context. For example, Resident Doctors of BC suggested that people with lived or living experience could be hired to lend their expertise during physician residency programs to address discrimination, racism, and culturally safe care in a classroom setting.

In addition, the Committee received a number of recommendations regarding human resources with suggestions to increase the overall number of health care professionals in the province and to also look at ways to incorporate more of certain professionals, such as social workers and psychologists, into the health care system to help respond to the drug toxicity and overdose crisis. For example, the Public Health Association of BC stated that the current investment in public health infrastructure is around three percent of the total health care budget, and noted that upstream investment in public health helps to rebuild the health care system's foundation and address surge capacity. The BC Nurses' Union told the Committee that nurses and nurse

practitioners have been working at unsustainable levels to address the dual health emergencies of the COVID-19 pandemic and the drug toxicity and overdose crisis, while the BC Association of Social Workers expressed that the province is not producing enough social workers to meet demand. The British Columbia Psychological Association stated that a key part of the solution is placing psychologists in family doctors' offices, as this is a critical environment to identify individuals experiencing addiction and intervene in terms of substance use treatment, as well as assessment and treatment of mental health more generally.

Still Here Recovery discussed the opportunity to incorporate recovery coaching into BC emergency departments. They explained that pairing recovery coaches with those being treated in hospitals following a toxic drug-related event provides an opportunity for interventions at a crucial time, and that evidence also shows that integrating recovery coaches into a care team can reduce strain on other hospital staff.

Supporting Families

Some organizations and individuals also noted the need for additional supports for family members of people who are addicted to drugs, noting the difficulties faced by these families, including those who have lost children to an illicit drug toxicity death. The Vancouver Island Federation of Hospices outlined that the grief caused by an illicit drug toxicity death can be compounded by the shame and stigma associated with substance use, and noted that support groups have seen promising results.

Services for Individuals in the Provincial Correctional System

BC Corrections noted that the BC Coroners Service 2018 death review panel report on illicit drug overdoses found that 66 percent of overdose deaths occurred among persons who had previous or current contact with BC Corrections, and of those, 10 percent died within 30 days of being released from custody. Resulting from the panel's recommendations, BC Corrections shared that it now provides naloxone kits to people released to the community and at its community offices, and it has worked to improve the care provided as individuals transition from custody into community. Benjamin Perrin also noted the days, weeks, and months after a person's release from custody are a crucial time since people are at an elevated risk of overdosing and dying.

With regard to providing treatment to individuals in the provincial correctional system, BC Corrections shared that there has been an increase in those that have received opioid agonist treatment (OAT), with data from early 2020 indicating that approximately 40 percent of people in the provincial correctional system are on some form of OAT while in custody. It noted that one of the challenges in providing support is that short stays do not always allow sufficient time for individuals to fully engage in treatment and recovery programs.

Committee Discussion

Committee Members discussed the critical role that community organizations—such as non-profits and community-led groups, including drugs user groups—play in responding to the drug toxicity and overdose crisis, especially in areas where there is a lack of other supports and services. They acknowledged that these groups are well-placed to identify and respond to community needs. The Committee discussed that many community groups highlighted that their current funding structure is piecemeal and short-term, and agreed on the need to provide these groups with sustainable and multi-year funding so they can dedicate more time to providing important services rather than to trying to secure funds.

Additionally, Members discussed the importance of accountability and coordination between these groups and the government to ensure that the work is been done effectively and is being appropriately supported. The Committee emphasized that accountability measures should be outcomes-based and people-centred to ensure that community groups are providing accessible services that are working for those who need them.

With respect to first responders, Committee Members discussed the vital role that they play responding to the drug toxicity and overdose crisis. Members expressed concern about the burden that has been placed on first responders, especially given limited personnel, and recognized that responding to this crisis has had a significant impact on first responders' mental health and wellbeing. Members noted that communities are being

impacted by a lack of timely response from first responders, since resources are being stretched to respond to calls related to mental health and toxic drug-related events. Therefore, the Committee discussed ways to support first responders, including by providing training and more resources, as well as alternative services that could assist in responding to the crisis. With respect to alternative options, Members noted that increasing the number of community paramedics, which is already underway, could help respond to the crisis, as well as further utilizing multidisciplinary community crisis response teams that are well-connected with community health and social services. Members supported the recommendation of the Special Committee on Reforming the Police Act to integrate mental health within 911 call options, in order to provide the most appropriate response.

Further, the Committee discussed ways to assist individuals who survive a toxic drug-related event, noting that first responders need to be able to make effective referrals to services to prevent future toxic drug-related events. In this regard, the Committee discussed the possibility of utilizing crisis lines and crisis support services as a way to provide wraparound supports such as follow-up calls after a toxic drug-related event, and follow-up calls at discharge from detox and recovery programs. Members were struck by the City of Surrey's second responder program where, after responding to a residential toxic drug-related event, a first responder will go back within 48 to 72 hours to check on the person along with a support team that can offer the person further assistance and referral to support services.

The Committee reflected on the work of the Special Committee on Reforming the Police Act, including its call for the creation of a continuum of response to mental health, addictions, and other complex social issues, with a focus on prevention and community-led responses and ensuring appropriate first response, and agreed that the government should work to quickly implement this recommendation.

Committee Members indicated that significantly increasing human resource capacity in the health care system is crucial to turning the tide of the drug toxicity and overdose crisis and that there needs to be a concerted effort to recruit, retain, and train additional health care professionals throughout the province. The Committee noted that this is especially important in rural and remote communities, which often face significant recruitment and retentions challenges as they must compete with urban centres to attract health care professionals. In addition, the Committee discussed the need to train existing health care workers and others who interact with high-risk individuals to identify substance use and to be able to refer individuals to appropriate services.

The Committee agreed that it would be beneficial to include additional professionals with expertise in substance use care—including addiction specialists, mental health professionals, and social workers—in hospital emergency departments. Members expressed that embedding these professionals in the emergency department would increase opportunities to provide referrals to harm reduction or treatment and recovery services for individuals who are at risk from the toxic drug supply.

The Committee acknowledged the profound impact of the drug toxicity and overdose crisis on families. Members noted the need to ensure increased resources for families who are supporting a relative with substance use challenges, as well as supports for those who are grieving the loss of a family member. They noted that families in these circumstances are also impacted by stigma about substance use. Further, Committee Members recognized that parents and caregivers who have suffered a loss often want to effect change, and reflected on the presentation from Moms Stop the Harm, which spoke about support groups the organization has created in response to this gap in resources.

Committee Members were struck by what they heard regarding the elevated risks of death due to illicit drug toxicity for individuals who have recently left the provincial correctional system, which underscored the need to have a transition plan in place prior to an individual being released from custody. As such, the Committee agreed there should be expanded access to harm reduction services and evidence-based treatment and recovery options for both those within and transitioning out of the provincial correctional system.

The Committee was pleased to hear the recent announcement that outlined the government's intention to double the number of Community Transition Teams (from five to 10) to provide support services to individuals leaving provincial correctional centres,

and to triple the length of time people get services from 30 to 90 days. However, Committee Members expressed concerns about the ongoing shortage of psychologists and psychiatrists to deliver adequate treatment and supports both within the provincial correctional system and to individuals who receive follow-up supports through the Community Transition Teams. The Committee questioned whether 90 days of follow-up services from these teams would be sufficient for those individuals leaving the provincial correctional system, and would like to see more fulsome monitoring of individuals after release to measure the effectiveness of follow-up supports and services.

RECOMMENDATIONS

The Committee recommends to the Legislative Assembly that the provincial government:

32. Provide sustainable, multi-year funding to community groups, including non-profits and community-led (drug user) groups, that includes accountability measures to support people-centred outcomes.

33. To better leverage the deployment of first responders to mental health and substance use crises, explore alternative options, including crisis response teams, and integrate a mental health option in 911 calls.

34. Create and fund significant additional human resources capacity to respond to the drug toxicity and overdose crisis through the retention, recruitment, and training of new and existing health care and social services professionals and peers.

35. Ensure additional, designated personnel are available in hospital emergency rooms to provide referrals to harm reduction or treatment and recovery services for individuals who are at risk from the toxic drug supply.

36. Expand supports and resources to family members of people who use drugs, including those grieving the loss of a family member due to the drug toxicity and overdose crisis.

37. Expand access to harm reduction services and evidence-based treatment and recovery options for both those within and transitioning out of the provincial correctional system.

Appendix A: Glossary

The following definitions are provided to ensure a common understanding of the terminology related to the Committee's report.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) can increase the risk of physical and mental illness later in life, including substance use disorders. ACEs are stressful experiences, such as abuse, neglect and household dysfunction, that occur before age 18. Understanding how ACEs affect brain development and shape health outcomes is essential for identifying risk for substance use and associated harms. This information can also help to identify points of intervention to try to prevent or treat substance use later in life. (Source: Canadian Centre on Substance Use and Addiction)

Decriminalization

An evidence-based approach to drug policy that is effective in reducing harms related to substance use when reinforced with complementary measures of harm reduction, prevention, enforcement, social support, and treatment. Redirecting police time and resources away from the enforcement of simple possession offences reduces barriers, including fear and stigma, and facilitates a linkage to treatment and harm reduction services. (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Drug Checking

A harm reduction service that offers a range of technologies that allow a sample of an unknown or suspected substance to be checked for the presence of one or more substances. (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Harm Reduction

Policies, programs and practices that aim to reduce the adverse health, social, and economic consequences of psychoactive substance use for people unable or unwilling to stop using immediately. Harm reduction is a pragmatic response that focuses on keeping people immediately safe and minimizing death, disease, and injury from high-risk behaviour. It involves a range of strategies and services to enhance the knowledge, skills, resources, and supports for individuals, families and communities to be safer and healthier. (Source: Overdose Prevention and Response Glossary, BC Government)

Naloxone

An opioid antagonist that blocks opioid receptors in the brain. Naloxone reverses the effects of opioids, including opioid overdose. (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Opioid

Any substance, both natural and synthetic, that bind to opioid receptors (e.g., heroin, morphine, methadone, and prescription pain relievers). (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Opioid Agonist Treatment (OAT)

Evidence-based treatment for opioid use disorder, which includes the administration of opioid agonists to alleviate withdrawal symptoms. Also referred to as opioid substitution treatment. Part

of a comprehensive treatment plan for opioid use disorder, which includes psychological and social supports. (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Overdose Prevention Sites

Services in some parts of British Columbia that were established as a response to the opioid overdose public health emergency, which provide people who use drugs a space where they can be monitored by health professionals, and receive treatment for an overdose if needed. (Source: Overdose Prevention and Response Glossary, BC Government)

People with Lived and Living Experience

The participation of people with lived or living experience in the planning, delivery and evaluation of programs, policies, services and supports can help make sure the system is taking a person-centred approach and better serving the needs of those individuals, as well as their families and friends. Lived experience refers to people who have used one or more substances and who are currently in recovery. Living experience refers to people who are currently using one or more substances. (Source: Canadian Centre on Substance Use and Addiction)

Safer Supply

Safer supply is a harm reduction approach that provides pharmaceutical alternatives to street drugs for people at high risk of an illicit drug-related death. (Source: BC Coroners Service Death Review Panel 2022 Report *A Review of Illicit Drug Toxicity Deaths*)

Substance Use Disorder

A diagnostic term for an illness in which the use of one or more psychoactive substances leads to clinically significant symptoms - including craving and inability to stop using despite negative consequences - that are detrimental to the individual's physical and mental health, or the welfare of others. The terms substance use disorder is the preferred current medical term for what is more commonly known as drug addiction or dependence. (Source: Overdose Prevention and Response Glossary, BC Government)

Supervised Consumption Services/Sites

Health services/sites where people consume drugs (that they have obtained elsewhere) in a hygienic environment, under the supervision of trained staff. The intent is to reduce the number of overdose deaths, connect people who use illegal drugs with healthcare services, including treatment and reduce public drug use and discarded used needles. These services/sites also provide opportunities to engage in other health and social services. (Source: Overdose Prevention and Response Glossary, BC Government)

Treatment, Support and Recovery

Treatment services and supports can help people experiencing harms from substance use or addiction. Services can include early identification and intervention, harm reduction approaches and relapse prevention. Services can also include peer support, specialized treatment, continuing care and more. Understanding that there is no one-size-fits-all treatment option is essential to providing the best possible care. By matching people with services that fit their needs, they can have a better chance of recovery. In addition, services and supports should be culturally appropriate, flexible, and tailored to the needs of the individual, to accommodate all people. They should also be acceptable, accessible, available and affordable. (Source: Canadian Centre on Substance Use and Addiction)

Appendix B: Presenters

Ambulance Paramedics and Emergency Dispatchers of BC, Dave Deines (14-Jun-22, Vancouver)

Archway Community Services, Natalie Deros (6-Sep-22, Virtual)

Dr. Jaime Arredondo Sanchez Lira (12-Jul-22, Victoria)

AVI Health and Community Services, Katrina Jensen (7-Sep-22, Virtual)

BC Addiction Recovery Association, Dr. Sherry Mumford (5-Jul-22, Vancouver)

BC Association for People on Opiate Maintenance, Howard Calpas, Hannah Dempsey, Jeff Louden, Garth Mullins, Brian O'Donnell, Ryan Maddeaux, Laura Shaver (16-Jun-22, Vancouver)

BC Association of Chiefs of Police, Chief Mike Serr, Sergeant Shane Holmquist (6-Jul-22, Vancouver)

BC Association of Social Workers, Michael Crawford (14-Jul-22, Virtual)

BC Centre for Disease Control, Dr. Réka Gustafson (4-May-22, Victoria)

BC Centre on Substance Use, Cheyenne Johnson (4-May-22, Victoria)

BC College of Family Physicians, Toby Achtman Dr. Christine Singh, (9-Sep-22, Virtual)

BC College of Nurses and Midwives, Cynthia Johansen (4-Jul-22, Vancouver)

BC Coroners Service, Lisa Lapointe, Michael Egilson (16-May-22, Victoria)

BC Corrections, Lisa Anderson, Eric Gunnarson (7-Sep-22, Virtual)

BC Emergency Health Services, Jennifer Bolster, Dr. Michael Christian (6-Jul-22, Vancouver)

BC Métis Federation, Drake Henry, Kevin Henry (20-Jun-22, Vancouver)

BC Nurses' Union, Aman Grewal (12-Jul-22, Victoria)

BC Pharmacy Association, Geraldine Vance (14-Jul-22, Virtual)

BC Professional Fire Fighters' Association, Lee Lax (14-Jun-22, Vancouver)

BC Provincial Toxicology Centre, Dr. Aaron Shapiro, Dr. Sandrine Mérette (15-Jun-22, Vancouver)

British Columbia Centre on Substance Use and British Columbia Centre for Disease Control Joint Committee: Professionals for Ethical Engagement of Peers (PEEP) and People with Lived and Living Experiences (PWLLE) Committee, Hawkfeather Peterson, Katheryn Cadieux, Fred Cameron, Ashley Cole, Paul Choisil, Jessica Lamb, Kurt Lock, Jenny McDougall, Billy Morrison, Tanis Oldenburger, Kali Sedgemore, Laura Shaver, Shawn Wood (7-Sep-22, Virtual)

Canadian Mental Health Association, BC Division, Jonny Morris (16-Jun-22, Vancouver)

Central Interior Native Health Society, Shobha Sharma, Phyllis Fleury, Lauren Irving, James Olsen (14-Jul-22, Virtual)

Coalition of Substance Users of the North, Charlene Burmeister (5-Jul-22, Vancouver)

College of Pharmacists of BC, Suzanne Sloven (4-Jul-22, Vancouver)

College of Physicians and Surgeons of BC, Heidi Oetter (4-Jul-22, Vancouver)

Construction Industry Rehabilitation Plan, Vicky Waldron (6-Jul-22, Vancouver)

Construction Industry Steering Committee on the Opioid Epidemic (CISCOE), Vicky Waldron, Chris Atchison, Dr. David Baspaly, Chris Gardener, Donna Grant, Lee Loftus, Colby Young (7-Sep-22, Virtual)

Cool Aid Society, Kathy Stinson, Dr. Chris Fraser, Nikki Page (11-Jul-22, Victoria)

Council of Construction Associations, Dr. Dave Baspaly, Grant McMillian (11-Jul-22, Victoria)

Covenant House Vancouver, Chelsea Minhas (20-Jun-22, Vancouver)

Crisis Intervention and Suicide Prevention Centre of BC, Stacy Ashton (6-Jul-22, Vancouver)

Dan's Legacy, Tom Littlewood (16-Jun-22, Vancouver)

Dr. Kora DeBeck (14-Jun-22, Vancouver)

Downtown Eastside Women's Centre, Christine Wilson (8-Sep-22, Virtual)

E-Comm 9-1-1, Jasmine Bradley (16-Jun-22, Vancouver)

Edgewood Treatment Centre, Dr. Christina Basedow, Geoffrey Ingram (21-Jun-22, Vancouver)

Elizabeth Fry Society of Greater Vancouver, Shawn Bayes (5-Jul-22, Vancouver)

Emergency Communications Professionals of BC, Donald Grant, Carrie James (5-Jul-22, Vancouver)

Engaged Communities Canada Society, Upkar Singh Tatlay (3-Aug-22, Virtual)

Dr. Danya Fast (11-Jul-22, Victoria)

Federation of Community Social Services of BC, Michelle Bell (12-Jul-22, Victoria)

Guy Felicella (15-Jun-22, Vancouver)

Fire Chiefs' Association of BC, Fire Chief Karen Fry, Fire Chief Larry Thomas (6-Jul-22, Vancouver)

First Nations Health Authority, Dr. Nel Wieman (2-May-22, Victoria)

First Nations Health Authority, Richard Jock, Dr. Shannon McDonald (25-May-22, Vancouver)

First Nations Leadership Council, Cheryl Casimer, Chief Harvey McLeod, Kúkwpi7 Judy Wilson (2-Aug-22, Virtual)

Foundry BC, Steve Mathias (4-Jul-22, Vancouver)

Fraser Health Authority, Norm Peters, Christine Mackie, Dr. Ingrid Tyler (25-May-22, Vancouver)

Health Canada, Shannon Nix, Carol Anne Chenard, Jennifer Pennock, Christina Simpson (2-Aug-22, Virtual)

Interior Health Authority, Dr. Sue Pollock, Susan Brown, Dr. Paul Carey, Diane Shendruk (25-May-22, Vancouver)

Island Health Authority, Kathy McNeil, Dr. Sandra Allison, Keva Glynn (25-May-22, Vancouver)

John Howard Society of BC, Mark Medgyesi, Shannon Pedlar (14-Jul-22, Virtual)

Dr. Perry Kendall (14-Jun-22, Vancouver)

Kilala Lelum Health Centre, Elder Bruce Robinson, Dr. David Tu, Leah May Walker (15-Jun-22, Vancouver)

Last Door Recovery Society, Jessica Cooksey (21-Jun-22, Vancouver)

Legal Aid BC, Katrina Harry (22-Jun-22, Vancouver)

Métis Nation BC, Mike Mercier, Jillian Jones, Stephen Thomson (9-Sep-22, Virtual)

Ministry of Attorney General and Minister Responsible for Housing, Angela Cook (24-May-22, Vancouver)

Ministry of Children and Family Development, Carolyn Kamper, Kelly Durand, Deborah Headley, Kerry Shinners, James Wale (6-Sep-22, Virtual)

Ministry of Education and Child Care, Jennifer McCrea (24-May-22, Vancouver)

Ministry of Health, Stephen Brown (24-May-22, Vancouver)

Ministry of Labour, Trevor Hughes (24-May-22, Vancouver)

Ministry of Mental Health and Addictions, Christine Massey, Darrion Campbell, Darryl Sturtevant (24-May-22, Vancouver)

Ministry of Public Safety and Solicitor General, Wayne Rideout, Brian Sims (24-May-22, Vancouver)

Ministry of Social Development and Poverty Reduction, Robert Bruce (24-May-22, Vancouver)

Moms Stop the Harm, Deb Bailey (21-Jun-22, Vancouver)

Native Women's Association of Canada, Lee Allison Clark (6-Sep-22, Virtual)

Northern Health Authority, Cathy Ulrich, Kelly Gunn, Dr. Jong Kim (25-May-22, Vancouver)

Nurses and Nurse Practitioners of BC, Michael Sandler (12-Jul-22, Victoria)

Office of the Representative for Children and Youth, Dr. Jennifer Charlesworth, Samantha Cocker, Pippa Rowcliffe (11-Jul-22, Victoria)

Orchard Recovery Centre, Lorinda Strang (21-Jun-22, Vancouver)

Our Place Society, Julian Daly (11-Jul-22, Victoria)

Overdose Prevention Society, Sarah Blyth, Trey Helten (22-Jun-22, Vancouver)

PACE Society, Nour Kachouh (6-Sep-22, Virtual)

Pacific Association of First Nations Women, Char Leon (6-Sep-22, Virtual)

Pacific Community Resources Society, Jason Lesser (16-Jun-22, Vancouver)

Pacifica Housing Advisory Association, Caroline Ibarra (7-Sep-22, Virtual)

Parents Advocating Collectively for Kin (PACK), Hawkfeather Peterson (4-Jul-22, Vancouver)

Pain BC, Melanie McDonald, Dr. Sean Ebert, Dr. Annabel Mead, Brenda Poulton, Dr. Launette Rieb (12-Jul-22, Victoria)

PAN, Jennifer Evin Jones (5-Jul-22, Vancouver)

Peers Victoria Resources Society, Katyanna Booth, Donnie Barr, Chass Duff, Eric Van Pelt (6-Sep-22, Virtual)

Benjamin Perrin (8-Sep-22, Virtual)

PHS Community Services Society, Dr. Christy Sutherland (14-Jun-22, Vancouver)

Pivot Legal Society, Caitlin Shane (16-Jun-22, Vancouver)

Planet Youth Lanark County, David Somppi, Dr. Páll Ríkharðsson, Dr. Paula Stewart (2-Aug-22, Virtual)

Ministry of Health, Portugal, Dr. João Castel-Branco Goulão (2-Aug-22, Virtual)

Providence Health Care, Fiona Dalton (25-May-22, Vancouver)

Office of the Provincial Health Officer, Dr. Bonnie Henry (2-May-22, Victoria)

Provincial Health Services Authority, Dr. David Byres, Justine Patterson, Dr. Jat Sandhu, Dr. Vijay Seethapathy (25-May-22, Vancouver)

Public Health Association of BC, Dr. Shannon Turner (4-Jul-22, Vancouver)

Corey Ranger (15-Jun-22, Vancouver)

Resident Doctors of BC, Dr. Brandon Yau, Harry Gray (11-Jul-22, Victoria)

Richmond Addiction Services Society, Daniel Remedios (21-Jun-22, Vancouver)

Rural Empowered Drug Users Network, Amber Streukens (14-Jul-22, Virtual)

Dr. Kate Salters (21-Jun-22, Vancouver)

Salvation Army Victoria, Jeffrey Baergen (7-Sep-22, Virtual)

Saskatchewan Coroners Service, Clive Weighill (3-Aug-22, Virtual)

South Asian Mental Health Alliance, Kulpreet Singh, Shilpa Narayan (6-Sep-22, Virtual)

Still Here Recovery, Kevin Diakiw, Shelley Shadow (6-Sep-22, Virtual)

Students Overcoming Substance Use Disorder and Addictions (SOUDA), Gurkirat Singh (6-Sep-22, Virtual)

Substance Use Support and Employment Program, Johanna Li, Sarah Tamburri (14-Jul-22, Virtual)

The Bridge Youth and Family Services, Celine Thompson, John Yarschenko (14-Jul-22, Virtual)

Together We Can, Alex Lekei, Steven Hall (15-Jun-22, Vancouver)

Tsow-Tun Le Lum Society, Nola Jeffrey (12-Jul-22, Victoria)

Turning Point Recovery, Brenda Plant (5-Jul-22, Vancouver)

Dr. Mark Tyndall (21-Jun-22, Vancouver)

Dr. Karen Urbanoski, Dr. Brittany Barker (14-Jun-22, Vancouver)

Vancouver Aboriginal Community Policing Centre, Chris Livingstone (20-Jun-22, Vancouver)

Vancouver Area Network of Drug Users, Brittany Graham, Dave Hamm, Kevin Yake (15-Jun-22, Vancouver)

Vancouver Coastal Health Authority, Dr. Patricia Daly, Miranda Compton, Dr. Rupinder Brar, Vivian Eliopoulos (25-May-22, Vancouver)

Vancouver Island Construction Association, Rory Kulmala (12-Jul-22, Victoria)

Dr. Charlotte Waddell (3-Aug-22, Virtual)

West Coast LEAF, Sharnelle Jenkins-Thompson (4-Jul-22, Vancouver)

Western Aboriginal Harm Reduction Society, Lorna Bird, Brittany Graham, Flora Munroe, Kevin Yake (20-Jun-22, Vancouver)

Westminster House Society, Susan Hogarth (5-Jul-22, Vancouver)

WorkSafeBC, Andrew Montgomerie (8-Sep-22, Virtual)

Appendix C: Written Submissions

Mike Adam
David Adamson
Paula Adkins
AESHA (An Evaluation of Sex Workers' Health Access) Project
Jeremy Alexander
Katie Alexander
Michael Alexander
Murray Alexander
Anna Alger
Mya Alissandra
Matt Allan
Chad Allen
Megan Allen
Corina Alliston
Marion Ambler
Lee Anderson
Necole Anderson
Richard Anderson
Jules Andre-Brown
Correne Antrobus
Ben Appenheimer
Teresita Aristizabal
Emma Arkell
Casey Armstrong
Cathy Armstrong
Megan Armstrong
Sheryl Armstrong
Noah Arney
Association Advocating for Women and Community
AVI Health and Community Services
Kelcey Ayers
Nazli Azimikor
Harjaap Badesha
Heidi Bailey
Rachel Baird
Doug Baker
Ian Ball
Sydney Ball
Graeme Barber
Adèle Barclay
Reina Barnes
Susan Barth
Jane Bartle
Stacey Basist
Mark Bayrock
BC Chiropractic Association
BC Civil Liberties Association
BC Federation of Labour
BC First Nations Justice Council
BC Humanist Association
Patrick Beechinor
Lois Beischer
Kristina Belyea
Becky Belzile
Celena Benndorf
Sharon Bennett
Pete Berikoff
Kate Berniaz
Anitra Berry
Alexander Betsos
Grant Bierlmeier
Linda Bird
Cody Bisson
Amanda Blackmore
Tania Blair
Becky Blixrud-Dufour
Amanda Boggan
Chengyan Boon
Rebecca Booth
Emma Boshart
Heather Boswell
Mo Bot
Khalid Boudreau
Wayne Boulanger
Matt Boulton
Emma Bourassa
Jason Bourgoin
David Bouvier
Jason Boyce
James Breckenridge
Susan Brennan
Alyssa Brewer
Jessica Bridgeman
British Columbia Psychological Association
Adena Brons
Ellen Brown
Gordon Brown
Jacqueline Brown
Allan Bruce
Heather Brugger
Eric Brundin
Jesalyn Bruno
Elizabeth Bryan
Michael Bryant

Ed Bryson
Jade Buchanan
Jean Buckler
Juls Budau
Kivanah Bull
Joyce Bunge
Mae Burrows
Robyn Burton
Jarren Butterworth
Jenn Calado
Ken Caldwell
Alison Cameron
Carole Cameron
Campbell River Community Action Team
Emma Campbell
Leslie Campbell
Rebecca Campbell
Rod Campbell
Canadian Addiction Treatment Centres
Cassandra Cappello
Curt Carbonell
Pauline Carey
Carrier Sekani Family Services
Emily Carrington
Peter Cassidy
Castlegar & District Community Services Society
Kevin Cattell
Allister Cave
Carol Cbongping
Mark Cernovich
Ravinnipa Chaisang
Robyn Chan
Philip Chang
Lauren Chant
Kristi Charlie
Tammie Chernoff
Iva Cheung
Alex Chila
Pam Choi
Lynne Christensen
James Clarke
Naomi Clarke
James Clayton
Kristal Clement
Emerson Close
Rachel Coe
Robert Colburn
Julie Colero
Kimberly Collier
James Collins
Maya Collinson
Jennifer Connors
Evan Conroy
Tressa Cooper
Brian Copeland
Jeff Corber
Shawn Corrado
Chris Corrigan
Anne Cotter
Barbara Cousins
Rachel Coutts
Louise Cove
David Cowling
Selina Crammond
Lynne Cranna
Deborah Crawford
Gordon Creed
Meghan Creighton
Russell Cripps
Clara Cristofaro
Emily Cronk
Martin Cross
Joshua Culp
Sergio Cunial
Pat Cunningham
Vanessa Currie
Natalie Cushing
Rob Dahl
Sandra Dalgleish
Erin Dalzell
Diana Das
Mary Kathryn Davis
Taylor Dawn
Hettie de Beer
Jan de Beer
Matthew De Marchi
Loraine DeBelser
Ro deBree
Lynda Dechief
Kate Dembinski
Deangelo Demeritte
Mark Dennis
Crystal Derakhshan
Roshni Desai
Susan DeSandoli
Shayne Deville
Linda Devlin
Heather DeVouge
Victoria Dexter
Amy Dhanjal
Anna DiBell
Michael Diel
Andrea Dion
Dennis Dion
Catherine Disbery
Dana Dmytro
Colleen Dockerty
Doctors of BC
Stephanie Doerksen
Jessica Doerner
John Douglas
Alexander Dove
Peter Dowdy
Downtown Victoria Business Association
Dr. Cecilia Benoit and Dr. Andrea Mellor
Dr. Sun Yat-Sen Garden Society of Vancouver
Andrea Droege
Drug Prevention Network of Canada

Carolyn Drugge
Druglitter.info, openlittermap.com
Sandra L Dube
Carol Duncan
Don Duncan (on behalf of a group of physicians with an interest and expertise in Attention Deficit Hyperactivity Disorder (ADHD))
Trevor Duncan
Adrian Dunkerson
Laura Dunne
Shari Dunnet
Tom Durrie
Lucy Duso
Jan Dwyer
Rob Dwyer
Tyler Dwyer
EACH+EVERY: Businesses for Harm Reduction
Linda Eagland
Nick Eagland
Serena Eagland
Carolyn Eaton
Patricia Ebbels
Alice Edwards
Annmarie Elderkin
Coco Elgood
Ryan Elias
Emergent Biosolutions
Roger Emsley
Viki Engdahl
Diana Enns
Amanda Erickson
Brenda Erven
Mark Esterhuizen
Christine Evans
Thomas Evans
Thea Everett
Dirk Falconer
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Amanda Farrell-Low
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Rick Fence
Amanda Fenton
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William Field
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Monica Finn
Deniz Firat
Matthew Fischer
Cathy Fletcher
Jessica Fletcher
Lori Fontaine
Robert Ford
Kieran Forristal
Fraser Forsyth
Rolandshelley Fowlerminato
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Taylor Fredrich
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Cathy Freer-Leszczynski
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Tanya Fruehauf
Joni Fuller
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Susan Furlong
Mo Gaffney
Sarah Galbraith
Darren Galer
Darrel Ganzert
Jasmine Garcha
Terrie Garrod
Ian Gartshore
Judy Gaudet
Cloe Gautier
Anna Geeroms
Erin Gesner
Iryna Getman
Shannon Geue
Joel Gibbs
Mirella Gibeau
James Giebelhaus
Karen Giesbrecht
David Gilbar
Maiya Gillespie
Herb Girard
Alicia Gladman
Allan Glass
Shelby Glasstetter
David Gleeson
Ben Goerner
Joshua Goldberg
Grace Golightly
Carlos Gomes
Tiana Gordon
Jayden Gosal
Grand Chief Doug Kelly, Sto:lo Tribal Council
Joanna Gray
Christopher Green
Mardel Greenough
Dylan Griffith
Ray Griffiths
Lydia Groves
Ariss Grutter
Emily Guerrero
G Diane Guthrie
Jaime Guthrie
Gya' Wa' Tlaab Healing Centre Society
Caleb Haight
Daniel Hall
Ken Hall

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Doug Hamilton-Evans
Joanne Hammond
Carmen Handley
Brea Hanley
Emma Hanlon
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Kam Johal
Chris Johnson
Cindy Johnson
Elizabeth Johnson
Jerry Johnson
Lorraine Johnson
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Nicki Jonkman
Mark Joseph
Kaylee Junipet
Justice for Girls
Imre Juurlink
Linda Kaastra
Karsten Kaemling
Vikram Karuna
Carissa Kasper
Laurel Keating
Alexis Kellum-Creer
Anne Kemal
Michael Kenacan
Tracey Kerr
Alyssa Kertesz
Tyler Keys
Rachel Kilback
Stephen Klaver
Alex Klepper
Erin Knutson
Jeff Kormos
Stephanie Koropatnick
Justin Kovar
Sharla Kozlowski
Kaitlyn Kraatz
Holly Kretschmer
Sandra Kubert
Reena Kudhail
Miya Kudo
Stephanie Kulferst
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Christina Laffin
Chris Laing
Douglas Laird
Julie Laliberte
Mike Lam
Pamela Lampi
Sarah Lane
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Kirsten Larsen

Alex Lasinskyi
Rachel Lau
Marlee Laval-Collacott
Frederick Lawal
Zena Lawrence
Isabelle Lebeau
Wanda LeBlanc
Benson Lee
Jay Lee
Mark Lee
Jacqueline LeMaistre
Josh Lepinsky
Chloe Lesmeister
Jennifer Lester
Amy Letendre
Krista Levant
Morgan Lewington
Will Lewis
Cheryl Lightowlers
Caroline Lillico
Bronwyn Livingston
Bruce Livingstone
Karen Loewen
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Caroline Longcroft
Judie Longmuit
Adam Longstaffe
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Donald Scott MacDonald
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Timothy Mackey
Jennifer Mackie
Rod MacLeod
Ian MacPhail-Bartley
Fiona Macpherson
Sandra Macpherson
Julianne MacSween
Leslie Madison
Constance Mahoney
Lleah Main
Lauren Mainland
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Lisa Maloney
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Ezra Mandel
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Nicole Marcia
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Julia Marshall
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Sherri Maunsell
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Brian McCune
Chris McDiarmid
Maureen McDonald
Robin McDonald
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Bruce McGarvie
Caitlin McGuire
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John McKinnon
Ashleigh-Ann McLean
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Sarah Millin
Cheryl Mills
Jodie Millward
Tracey Minor
Margaret Mitchell
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William Moffat
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David Montford
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Sean Moores
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Justine Morley
Maciej Morycinski
Chris Moslin
Lorena Mota
Sharon Mott
Tega Mukoro-Okpodu
Angela Murray
Kathryn Murray
John Muth
Tara Myketiak
J Napier
Bruce Nelms
Robert Newton
Eleanor Ruth Nicholl
William Nicholls-Allison
Matthew Nicoll
Linda Nielsen
Shelley Noyes
Ron O'Brien
Joseph O'Connor
Carol Ogden
Frank Ogiamien
Beth Oldham
James Oldman
Graeme Oliver
Mark Oliver
Kristy Oshea
Pamela Owen
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Pacific Community Resources Society
Glenna Padley
Sanjeet Pakrasi
Katherine Palakovic
Andres Panti
Karly Paranich
Alicia Parisien
Morgan Parker
Cora Pavlis
Colby Payne
John Peachey
Brianna Pearce
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Marie Perrett
Marianne Pitt
Cristen Polley
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Tamara Randall
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Jack Reid
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Mike Rhone
Lisa Richards
James Richardson
Wendy Richardson
Charles Riddle
Beverlee Ridsdale
Dr. Launette Rieb
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Mary Rinfret
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Remy Risler
Tarina Rissanen
Mark Ritchie
Alissa Rivet
Sam Roberts
Ian Robertson
Katie Robertson
Chris Robinson
Melissa Roe
Elizabeth Roger
Jo-Anne Rogers
Linda Rollins
Mandy Root
Andrew Ross Collins
Donald Ross
Maria Roth
Kit Rothschild
Lea Rowland
Nikita Rozhkov
Brent Rushton
Griffin Russell
Rebecca Ryan
Mala Sahan
Amy Salimian
Jesse Samuels
Aylen Sanchez
Paul Sanchez
Bert Sandie
Daniel Sands
Samantha Savage
Laura Savinkoff
Terry Sawatsky

Darren Schemmer
Max Schroeder
Abigail Schultz
Allison Schulz
Geoffrey Scott
Samantha Scouse
Ashley Seatter
Zelik Segal
Louise Seltenrich
Amanda Serres
Pierce Sharelove
Tracey Shephard
Boris Shubin
Jennifer Simmonds
Tyson Singh Kelsall
Christine Singh
Randy Singh
Catherine Skelly
Tara Skobel
Lenord Skowaisa
Christopher Smendziuk
Catherine Smith
Mary Smith
Ramona Smith
Rich Smith
Shauna Smith
Cameron Smithers
Curtis Snider
Taylor So
Andrew Soch
Luke Solvang
Karen Sorenson
Rufus Spalding
Janette Sperber
Julie Springett
Judith Stamps
James Stanley
Braden Staudacher
Crystal Stavrakov
Kim Steadman
Joanne Stecko
Keven Stephens
Valeria Stephens
Shelley Stevens
David Stevenson
Amanda Stewart
Jennifer Stewart
Julia Stewart
Ramona Stimpfl
Lorna Stocker
Eli Stoffman
Lindsay Stokvis
Lori Stolson
Annie Storey
Sts'ailes - Telmexwawtexw
Sonja Sundqvist
Aaron Swanson
Jean Swanson
Breanna Switzer
Elan Symes
Allen Szafer
Tammy Tanner
Bri Taylor
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Nancy Telford
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David Thain
The Alma Mater Society of the University of British Columbia Vancouver
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Jenny Thomas
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Madison Thulien
Joelle Thurston
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Ingrid Tilstra
Keenan Tims
James Tirrul-Jones
Andrea Tisher
Raphaël Titsworth-Morin
Blue Topping
Ruth Torres
Lynne Tourond
John Trotter
John Trueman
Paul Trump
Liz Tuck
Jordan Tucker
Alexis Turner
Ann Turner
Katia Tynan
Ross Tyner
Shannon Udall
Lynn Uhrynchuk
Brad Ulmer
Umbrella Society
Union Gospel Mission
Union of British Columbia Municipalities
UVic Law Students for Harm Reduction & Decriminalization
Tecla Van Bussel
Marlo Van Marck
Rana Van Tuyl
Vancouver Island Federation of Hospices
Janice Vanderspek
Deanna Vernelli
Victoria Brain Injury Society
Victoria Cannabis Buyers Club
Victoria Community Action Team
Victoria Youth Clinic
Dzung Vo
Karen Von Muehldorfer
Lauren Wagar
Wagner Hills Farm Society

Wesley Wagner
Joyce Walsh
David Walters
Jesse Walters
Mona Wangler
Johanna Ward
Karen Ward
Kee Warner
Kenneth Warner
Hayley Watt
Sandra Weal
Lorraine Weaver
Martin Wedepohl
Valerie Weedon
Jared Wegenast
Jeff West
Natalie Whelan
Drea White
Dave Whitehead
Aidan Whiteley
Richard Whittaker
George Wiedmann
Jennifer Wiegele
Brian Williams
Cynthia Williams
Jason Williams
Pat Williams
Richard Willier
Erin Willis
Jon Willson
Robert Wilmot
Ryan Wilson
John Winters
Sarah Winters
Hayley Wlasichuk
Gillian Wong
Susanna Wong
Bryan Wood
Thomas Wood
Jeff Woodyard
Kathy Yardley
Ashley Yates
Bori Yoon
Richard Young
Lanika Yule
Loretta Zahar
Karin Zeitler
Charlotte Zesati
Airuo Zhang
Siling Zhang
Peter Zhou
Xiaoying Zhou
Bruce Zimich