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HORIZONS

THIS ISSUE: OPIOIDS

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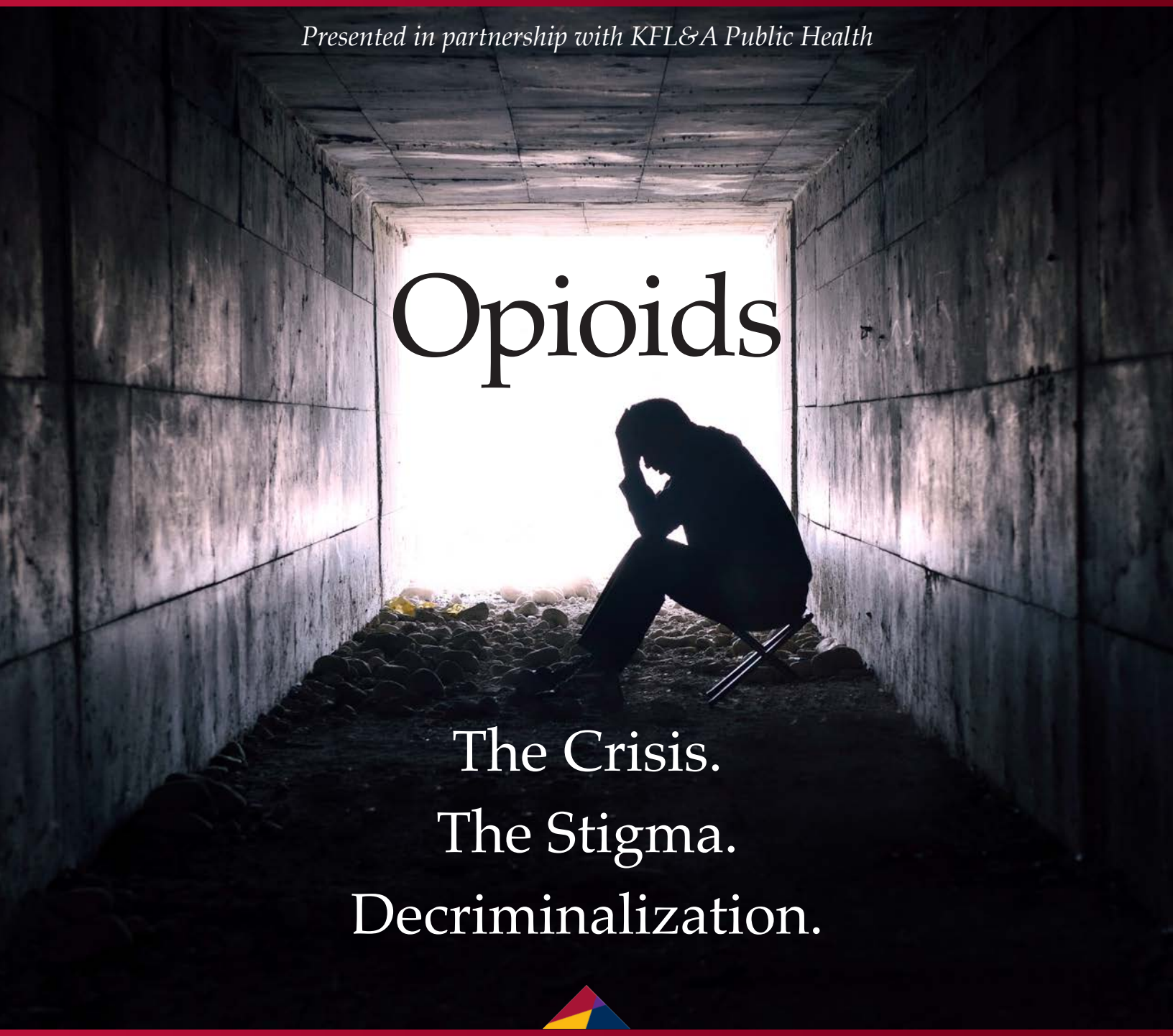

Opioids

The Crisis.
The Stigma.
Decriminalization.

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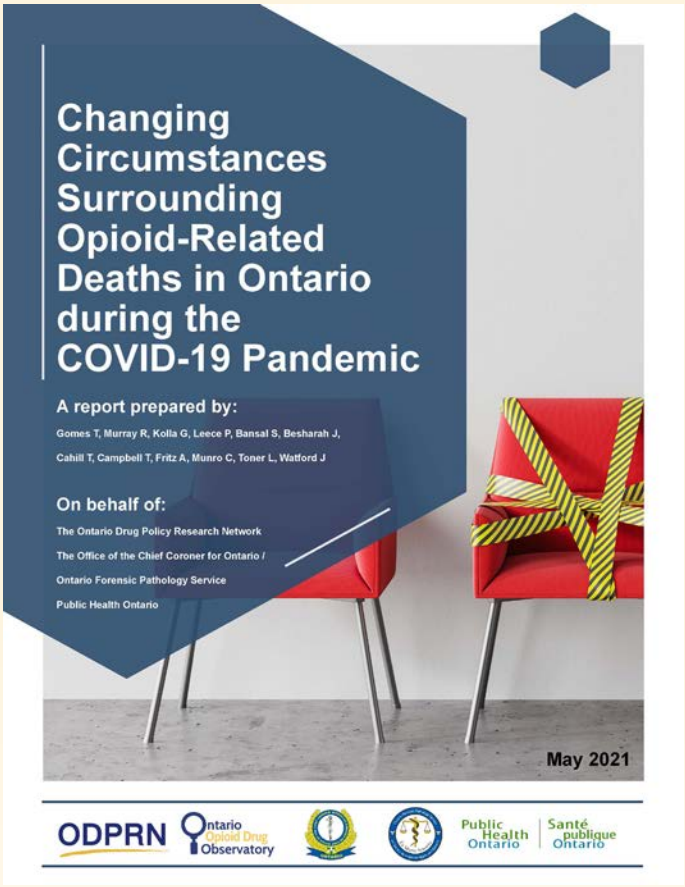
The Drug-Poisoning Crisis in KFL&A:

The Landscape and Opportunities for Action

By Tia Maatta and Susan Stewart

The drug-poisoning crisis, marked by high rates of opioid-related deaths, is a significant and longstanding public health issue in our country, our province, and our community.

In 2020, there were more than 6,200 apparent opioid-related deaths across Canada — this equates to approximately 17 deaths per day.[2] In the last quarter of 2020, from October to December, there were more than 1,700 apparent opioid-related deaths across Canada.[2] This represents a 100 per cent increase from the same period in 2019, and the highest quarterly count since national surveillance began in 2016.[2]



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Sadly, provincial and regional trends are consistent with the national data. In 2020, more than 2,400 people in Ontario died of a confirmed or suspected opioid-related death.[3] Following the COVID-19 pandemic state of emergency declaration in March 2020, there has been a 79 per cent increase in opioid-related deaths across the province.[3] The majority of these deaths occurred among men, aged 25–44, in private residences and when people were alone (i.e., there was no one present to intervene).[3] Nearly all deaths (96 per cent) were accidental (i.e., unintentional).[3]

In Kingston, Frontenac, Lennox & Addington (KFL&A), there were 42 deaths due to accidental drug overdose poisonings in 2020, up from 32 deaths in 2019. It is anticipated that this trend will continue for 2021; preliminary data suggests five opioid-related deaths* in KFL&A in the first three months (January-March) of 2021.[1]

While there is a lag in mortality and morbidity data, it is likely that trends have continued to worsen in 2021. Reports from local community partners suggest that fatal drug poisonings are occurring at alarming rates; that overdose events are complex (individuals may not respond quickly to standard resuscitation attempts with naloxone); and that effects such as sedation and disorientation can last for hours. Hospital visit data reflects a record-high number of opioid overdoses in KFL&A for late April and early May 2021. From February 2020 to July 2021, a total of eight community alerts were issued to warn residents of a heightened risk of drug overdose. Partners who work directly with people who use drugs are pleading for change, noting that current responses are not sustainable.

While the opioid crisis pre-dates COVID-19, the pandemic has exacerbated rates of adverse outcomes such as fatal drug poisonings. Many factors have been cited to explain this, including the increasingly toxic drug supply; increased feelings of isolation, stress, and anxiety; and reduced availability of services for people who use drugs.[2] An increasingly toxic drug supply refers to the unexpected contamination of substances with additional or more potent substances, increasing the risk of drug poisonings.

During the pandemic, the contents and potency of substances has become increasingly unpredictable as border closures have disrupted supply chains and caused changes to manufacturing. The frequency with which other substances, such as fentanyl,

benzodiazepines, and stimulants, have contributed to opioid-related deaths has increased during the pandemic. For example, fentanyl directly contributed to 87 per cent of opioid-related deaths across Ontario during the pandemic, compared to 75 per cent before the pandemic.[3] In May and June 2021, drug toxicology reports in KFL&A revealed the presence of fentanyl, carfentanil, and benzodiazepine analogues in the local drug supply.

In order to disrupt these concerning trends and reduce preventable deaths, it is critical that communities come together. To address the harms of drug use, a comprehensive and cross-sector strategy is needed. Such a strategy would include elements of prevention, harm-reduction, treatment, and enforcement.

Across KFL&A, agencies are offering training and education on topics such as substance use-related stigma, trauma-informed care, and adverse childhood experiences (ACEs), which refers to stressful or traumatic events in early years that influence health and well-being later in life.[4] Adverse childhood experiences are common, and dramatically increase the risk of substance use and substance use disorder.[4]

Recognizing substance use as a response to psychological trauma, as an approach to cope with or alleviate pain, is imperative to reduce stigma towards people who use substances. Stigma may drive folks to use drugs alone or in secret, increasing the risk of fatal overdose, and it is well-established that stigma serves as a significant barrier to seeking help. (Read Andrea Keller and Barb Cahill's personal accounts about the profound impacts stigma has had on their families on the pages that follow.)

Additional efforts are underway to reduce substance use-related harms across the community. The Kingston, Frontenac, Lennox & Addington Community Drug Strategy is a cross-sector planning table committed to advancing community-wide approaches that promote health, equity, and dignity for people who use drugs. The group recently released a statement of support for the decriminalization of people who use drugs and the four local municipalities of the County of Lennox & Addington, Frontenac County, Frontenac Islands, and the City of Kingston have endorsed this statement.

Decriminalization, which differs from legalization, refers to applying non-criminal responses to certain activities, such as the possession and personal use of drugs. It is an evidence-informed approach that positions drug use as a health issue, rather than an issue of morality, will power, or criminal justice.

While decriminalization is an important component in addressing stigma and improving outcomes for people who use drugs, it is not a stand-alone solution. Additional, complementary approaches, such as safer supply programs, warrant exploration. These programs can vary in design, but generally involve providing people that have a substance use disorder with a pharmaceutical-grade supply of substances such as opioids. Possible benefits of safer supply programs include reduced risk of fatal overdose due to contaminated substances, enhanced engagement with health-care providers, and reduced rates of criminal activity in which folks may otherwise participate in order to secure substances.[5]

Recognizing substance use as a response to psychological trauma, as an approach to cope with or alleviate pain, is imperative to reduce stigma.

With input from the community, the Community Drug Strategy will continue to explore options for reducing substance use-related harms and better supporting local community members who use substances.

**Data includes confirmed and probable cases. It should be considered preliminary as it is subject to change.*

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Susan Stewart is Director, Family & Community Health, at KFL&A Public Health and the KFL&A Community Drug Strategy Advisory Committee Chair.

REFERENCES

1. Public Health Ontario. Interactive Opioid Tool: *Opioid-related morbidity and mortality in Ontario*
2. Government of Canada. *Opioid- and Stimulant-Related Harms in Canada (June 2021)*
3. Gomes T, Murray R, Kolla G, Leece P, Bansal S, Besharah J, Cahill T, Campbell T, Fritz A, Munro C, Toner L, Watford J on behalf of the Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario and Ontario Agency for Health Protection and Promotion (Public Health Ontario). *Changing circumstances surrounding opioid-related deaths in Ontario during the COVID-19 pandemic*. Toronto, ON: Ontario Drug Policy Research Network; 2021
4. Samhsa's Center for the Application of Prevention Technologies. *The Role of Adverse Childhood Experiences in Substance Misuse and Related Behavioral Health Problems*
5. Ontario HIV Treatment Network. *Possible benefits of providing safe supply of substances to people who use drugs during public health emergencies such as the COVID-19 pandemic*

Somebody's Someone

By Andrea Keller

"Low-life" … "Junkie" ... "Deserve what they get" … "Meth head" … these are just a few of the terms that are regularly used to describe a person who uses substances. I see it in a different light. Son ... Daughter … Mother … Father ... Partner ... Friend ... Someone who is hurting.

How do you view people who use substances? I could provide numerous statistics on substance use-related deaths or refer to research on the negative impacts of stigma or the importance of harm-reduction approaches. I could describe that we need more recognition from the government, more money for programs, and more resources for people who use substances, but, instead, I will discuss the human side of substance use.

Harm reduction, decriminalization, enhanced resources, and other similar efforts will all certainly help to combat the global opioid epidemic, but until we stop the stigma, and recognize this for what it is — a medical crisis — we cannot fully address it or improve outcomes for people who use substances.

Not one person who uses substances ever wakes up and says, "I want to be addicted to a substance. I want to be controlled by an addiction day after day. I want to be compelled to give up everything just to satisfy my craving — to lose my family, my job; to live on the street; to live in constant pain and despair; and to be treated like someone who doesn't matter."

Addiction can be defined as "a psychological and physical inability to stop consuming a chemical, drug, activity, or substance, even though it is causing psychological and physical harm." If we reflect on this definition, and root causes of substance use, we can recognize that addiction is not a choice.

Tyler James Keller (January 5, 1991–March 18, 2017)

Tyler's Story

On March 18, 2017, my life changed forever.

I was at work at Kingston Health Sciences Centre when I received a call that I needed to meet my boyfriend in the main lobby. As I entered the lobby I saw my boyfriend, and standing beside him was a Kingston Police officer. Their faces were grim, and I knew that something was seriously wrong. My heart was pounding, and to this day I can still see exactly where they were standing.

As I approached, they asked me to take them to my office. On my way, a terrible feeling came over me and I asked if something had happened to my son Tyler. The officer said, "Yes." I asked if he was dead, and she replied, "Yes." As we proceeded to my office, the tears were flowing. I was in shock. My oldest son was gone, dead from a multi-drug toxic drug poisoning.

Tyler was 26 years old. He struggled with his mental health his whole life. I had him in counselling numerous

times, but it just wasn't enough. Tyler was gay, and he found it very hard growing up as he encountered much stigma. He didn't do well in school and couldn't learn the same way as other children. He resisted seeking help due to the stigma he encountered.

Tyler was a great person. He was always happy and was always the life of the party. Everyone loved him. However, like many people who use substances, Tyler was hurting inside. He suffered much childhood trauma, with several deaths of close family and friends, and he turned to drugs to cope with the pain and helplessness he felt.

Many people who use substances have suffered some sort of trauma or multiple traumas in their life and many are also suffering from mental illness. Trauma can come in many forms and varying levels, and when someone experiences psychological trauma, physiological changes happen inside the body. Addictions, to drugs and other substances and things, can be the result of people trying to soothe their pain.

People who use substances come from all walks of life. Addiction does not discriminate, as pain does not discriminate. People struggling with substance-use disorder need kindness, respect, love, acceptance, and hope.

The Impact of Stigma

In health care, people who use substances or who have mental illness are often treated much differently than other patients. I have encountered this many times in my long career as a nurse, and unfortunately have overheard many upsetting comments. I once heard a fellow nurse say, "I wish we could just look after the real sick people" when a patient who was experiencing mental health issues and was intoxicated by substances presented at the emergency department. It breaks my heart to think that people who are as sick as anyone else coming to the hospital would be stigmatized and mistreated.

Someone with substance use disorder may respond to the stigma they experience by lashing out, especially when they see that they are being treated differently than others. Their "difficult behaviours" are their coping mechanisms.

Stigma from others can profoundly change how people feel about themselves and can lead to internalized feelings of hopelessness and shame in those struggling to cope. This, in turn, can create serious barriers to seeking help. Why would someone want to seek help in a place where they are shamed, disrespected, and treated as a nuisance? Our demeanor, body language, and words can reveal how we really feel towards people who use substances.

What Can You Do?

The number of overdose deaths and toxic drug poisonings is rising every day in this region, province, and country, and around the world. To disrupt current trends, we must change how we look at this global, drug-poisoning crisis. People who use substances, people who are suffering, deserve our love and support. People with substance-use disorder deserve the same access to treatment that any person with any illness has available to them. To change the way we look at and treat people with substance use disorder, we have to end stigma.

When you encounter people who use substances, be kind and patient. When we look beyond a particular behaviour we can see a broken soul, a person desperate to find peace, and someone who needs our help and kindness. Our acts of kindness, a smile on a dark day, could change a person's life forever.

These people are "somebody's someone." Many of these people have families that are suffering along with them, who do not know where to turn for help, who spend days and nights hoping their family member is OK and worrying that they may receive a call with the unimaginable news that their loved one is dead.

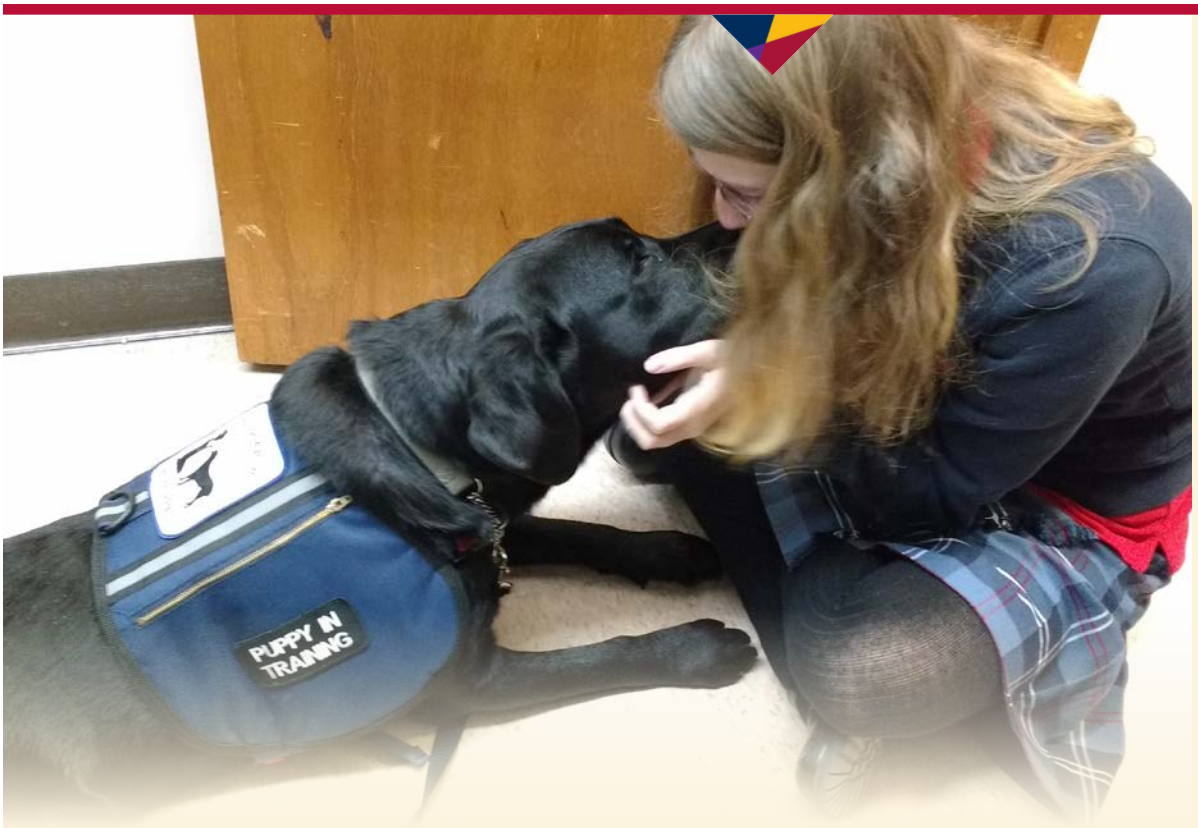
Give HOPE to someone who is hopeless.
HELP to someone who is helpless.
LOVE to someone who does not know love and does not love themself.
RESPECT to someone who does not respect themself.
KINDNESS to someone who is lonely.

Until we start treating addiction as a disease and treating people who use substances with compassion and kindness, there will be thousands of families every day suffering the grief and loss that my family has experienced. I often wonder, if there was not so much stigma in this world, if my son might still be alive.

My hope for Tyler's memory is that I can change even one person's attitude towards substance use and mental illness.

Please, stop the stigma.

Andrea Keller is a registered nurse and Manager of Patient Observation at Kingston Health Sciences Centre. She works with patients and staff to develop individualized care plans, introducing risk-reduction strategies to address responsive behaviours in patients. Andrea is a member of the KFL&A Community Drug Strategy advisory committee and subcommittees, and a member of Moms Stop the Harm Canada.



Baily, Youth Diversion's therapy dog, shares some love at a Kairos Program session. Kairos, a counselling service specializing in treatment for youth who are experiencing substance use/misuse, personally or with a family member, is available as an outreach program in all KFL&A elementary and secondary schools.

Photos courtesy Youth Diversion.

The Struggling Youth

Contributing Factors that Fuel the Journey

By Shawn Quigley

This narrative is about the impact of the drug-poisoning crisis in KFL&A, which includes our opioid catastrophe and the call to decriminalize personal use of illicit substances. However, to begin there would do a disservice to everyone who has struggled or is struggling with a substance use issue. To tell this story, we need to explore the underlying factors that contribute to one's journey through substance use.

"Behaviorally challenged kids are behaviorally challenged because they don't have the tools/skills necessary to not be challenging," says Dr. Ross Green, creator of Collaborative Problem Solving and author of *Lost at School* and *The Explosive Child*. It's a simple yet very complex statement that is at the core of the work we do.

If a person could do well, why wouldn't they? Isn't it preferable that if we have the appropriate tools and skills, doing well becomes that much more achievable? Youth simply do not wake up in the morning and aspire to become addicted to a substance, quit school, become criminally involved, create victims, or find themselves homeless or human trafficked. And yet there is still the consensus that they have a choice. It is this consensus that is at the foundation of stigma in our community.

What don't we know?

A vast amount of research has been validated over the years helping us better understand how and why youth make the decisions they do. We know that the underdeveloped adolescent brain has young people at a disadvantage when it comes to sound decision-making. Young people are impulsive and misread social cues, and they engage in dangerous behaviours such as fighting, running away, or using substances. They are less likely to think before they act or to consider the impact of their actions on others.

Then you can add adverse childhood experiences (ACEs) to this mix and ask yourself, do youth do well because they can or because they want to? Adverse childhood experiences are potentially traumatic events that can be present in a young person's life. They may include:

- experiencing violence, abuse, or neglect;
- witnessing violence in the home or community;
- having a family member attempt or die by suicide; and
- experiencing a lack of safety, stability, and bonding while growing up in a household where substance use, mental health issues, or inconsistent parenting is present.

The United Way KFL&A recently conducted a survey of young people, trying to better understand youth homelessness and how to prevent children and youth from having to resort to the streets. Youth told us that family conflict, mental health issues, substance use, school failure, and lack of access to employment were the key factors that led them to being unsheltered, precariously housed, or at risk of being homeless.

Lastly, we must examine the role of risk and protective factors in a young person's life, as they play a key role in understanding both the foundation of a young person and how to mitigate these factors.

Risk factors are characteristics at the biological, psychological, family, community, and cultural level that precede and are associated with a higher likelihood of negative outcomes. Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact.

It is important to point out that with all the challenges listed here, many youth navigate adolescence and do come out the other side as functioning, contributing members of our community because they were able to build resilience, and just over 50 per cent of them had one thing in common: one kind, caring, nurturing, and available adult role model in their life.

As our community slowly comes out of COVID, the one overwhelming constant that has plagued us, before the pandemic and exacerbated during the pandemic — and no doubt will remain a crisis long after it's over — is the impact of the opioid catastrophe and the tragic loss of life in our community due to drug poisoning.

Between January 2020 and June 2020 alone, we lost 32 people (one person every five days) in KFL&A and had more than 100 emergency-related events due to the opioid catastrophe and drug poisoning. It is time we, as a community, take a deeper look into what it would mean to decriminalize the personal use of illicit substances.

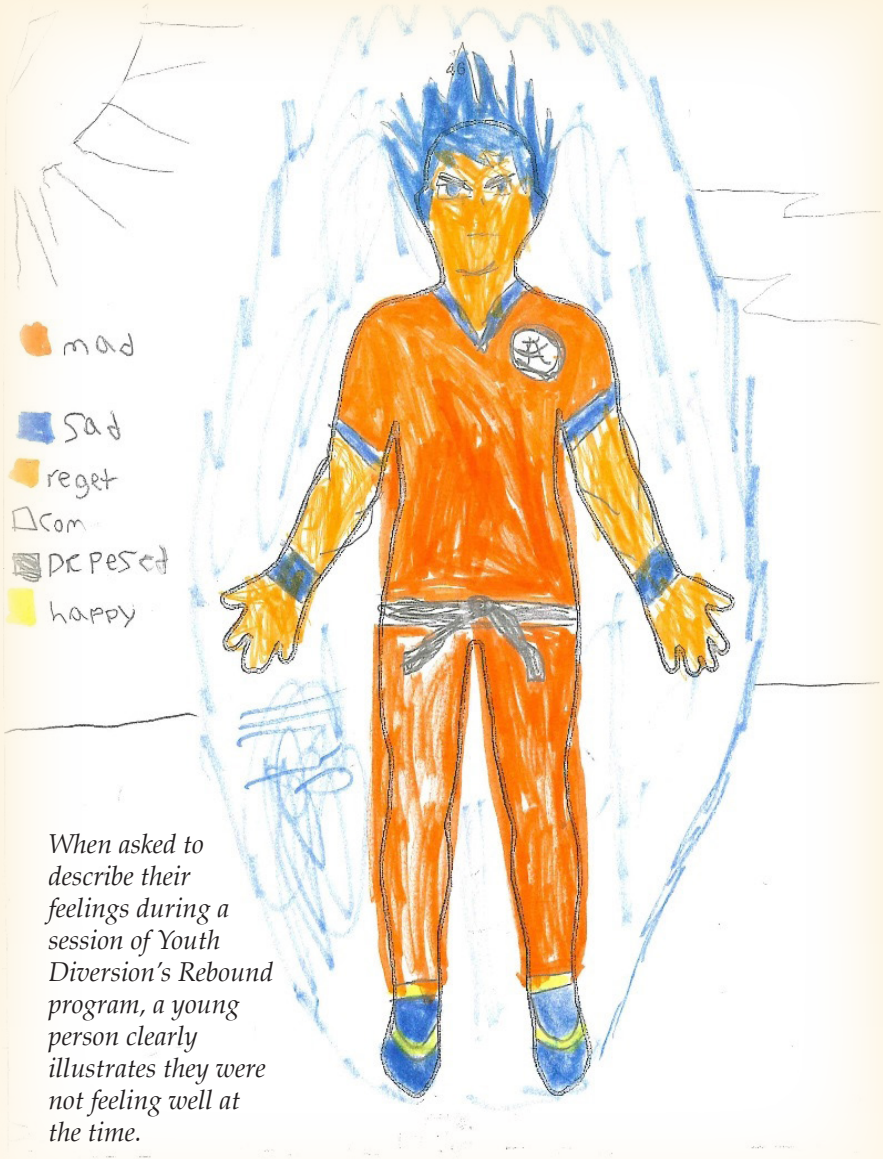
Our local Community Drug Strategy (CDS) recently endorsed the decriminalization of people who use drugs, stating that this approach is evidence-informed and will address the unrelenting overdose crisis in our community. We need to start seeing drug use for what it is — a health issue and not a criminal justice issue.

When the legalization of cannabis was introduced in Canada almost three years ago, it did not have the desired effect of reducing usage among young people. What we did see was an increase in dialogue, more accurate information, and comprehensive research made available —and there is indication of a reduction in stigma — culminating in better-informed youth.

A Youth Diversion mentor and mentee embrace the invitation of a calling tree during a nature hike.

From a harm-reduction point of view, this new knowledge furnished youth with the capacity to make more informed decisions about choosing to use cannabis. Agencies such as Youth Diversion have been provided the resources to better educate youth and front-line staff about substance use and addiction literacy.

I would be remiss if I did not acknowledge that there will always be harm attached to early substance use among youth. We've seen firsthand what drug-induced psychosis can do; how substance use impacts the developing adolescent brain; and the struggles families cope with, most often in isolation. The fact remains that some youth will continue to experiment with substances regardless of the legal implications because that is how their brains are programmed.



When asked to describe their feelings during a session of Youth Diversion's Rebound program, a young person clearly illustrates they were not feeling well at the time.

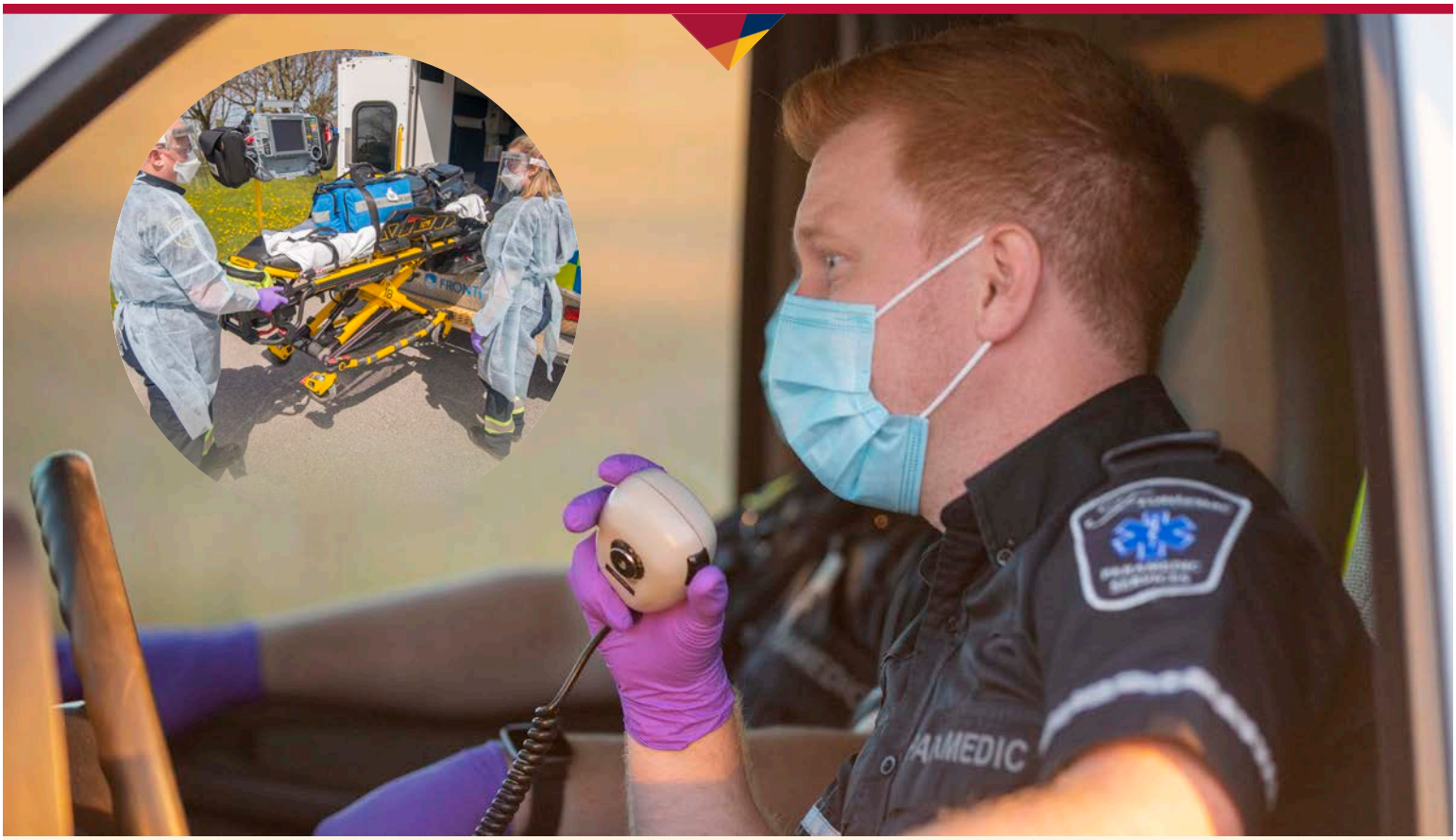
We constantly grapple with the balance between enforcement and harm reduction, but the reality is, substance misuse and addiction are mental health concerns that need solutions rooted in a mental health approach in order to disrupt the cycle of criminalization. Many people who need the services of our local Integrated Care Hub had their first experience in the justice system as a youth and they now attribute the beginnings of their struggles with this early exposure to police and courts. Withholding available treatment from sick patients would be unthinkable, yet people struggling with a substance use disorder are seen as a product of their own circumstance and passed aside.

There was a time not long ago when we treated young people with a mental health concern as lazy, disengaged, or looking for attention. We had to experience the ramifications of this thinking the hard way, but we are now figuring it out. Today, our schools have social workers, youth workers, and better-trained school staff to identify and support mental health issues among students. We have managed to tackle the ignorance and stigma attached to mental health, and these efforts are beginning to lift the veil of mental health.

Decriminalizing the personal use of illicit substances at first thought is difficult to comprehend because, I would argue, we see this action through the lens of crime and punishment and not through health and compassion. We need to be thoughtful, thorough, and inclusive as we continue to engage in dialogue pertaining to this essential journey.

When we are ready to ask, "What happened to you?" as opposed to, "What have you done?" then we will be ready, as a community, to overcome this challenge.

Shawn Quigley is the Executive Director of Youth Diversion. He oversees a number of youth-serving programs, including Kairos Substance Use and Addiction Services.



Photos courtesy Frontenac Paramedics.

Paramedics and the Opioid Crisis:
An Emergency-Management Lens

By Marc Goudie

Canada is currently embroiled in an opioid epidemic, seeing opioid-related deaths increasing since 1999 and then dramatically increasing from 2016 and onward.[1] Locally, within Kingston, Frontenac, Lennox & Addington, our situation has been reflective of national trends.[2] The opioid crisis has not spared our community; in fact, emergency department visits and deaths attributed to opioid use is higher than Ontario rates.[3]

The COVID-19 pandemic has only exasperated the situation. Ontario saw a 60 per cent increase in opioid-related deaths in 2020 from 2019.[4] This increasing trend is reflective of a corresponding increase in calls to Frontenac Paramedics. In the last two years, the service has seen a dramatic increase in opioid-related calls in our community.

Paramedics in Frontenac contribute beyond their traditional role of responding to emergency 911 calls when it comes to the opioid crisis. In order to respond to our community's needs, a comprehensive emergency-management framework has been implemented that includes the following four components: prevention and mitigation, preparedness, response, and recovery.[5] These components are interconnected, and aim to reduce the overall burden emergencies have on individuals and society at large.[5] Using this perspective, you will see how Frontenac Paramedics is involved in dealing with the opioid crisis, our community, and with people who use opioids.

Prevention, as a component of emergency management, aspires to avoid an emergency altogether and mitigation seeks to lessen the effects of an emergency when it does happen. An example of prevention could include not building homes in a known floodplain and, along the same vein, mitigation efforts could include raising homes to prevent flooding.

In the context of the opioid crisis, preventive measures come long before opioids are ever consumed. Prevention strategies could include responsible prescribing, eliminating poverty and homelessness, and preventing adverse childhood experiences. On May 19, 2021, the County of Frontenac Council passed a motion to support the KFL&A Community Drug Strategy advisory committee's statement in support of decriminalization

of people who use drugs. This is an important step in preventing harms associated with opioid use in our community.[6]

An important role paramedics play in mitigating the impacts of the opioid crisis is their work at Kingston's Consumption and Treatment Services Site (CTS). Together with service-delivery partners, paramedics provide on-site medical support for people accessing the CTS to consume substances in a safe space, where immediate help is available should they experience an unintentional overdose. Paramedics are well-suited for working at the CTS, as they are accustomed to working in non-clinical settings and have the skillset to deal with an overdose, should one occur. Clients can also access a variety of other services and safe consumption supplies at the CTS.

Preparedness refers to actions taken prior to an emergency to help manage its impacts and ensure response-readiness. Two important things come to mind when I think about paramedic preparedness in the opioid crisis. The first is Frontenac Paramedics' partnership with KFL&A Public Health, which is provided with near real-time alerts when patients are treated with naloxone or an opioid overdose is suspected. This helps in the early identification of toxic batches of drugs that may be circulating in our community.

The second is Frontenac Paramedics will soon be able to replenish naloxone kits for bystanders and family members who may have used these kits to save someone from an overdose. Paramedics will be receiving training on the dispensing of naloxone kits in their upcoming fall professional development cycle. Having a naloxone kit — available free from KFL&A Public Health and a variety of pharmacies and community organizations — in the presence of an overdose could be the thing that saves someone's life.

Responding to emergencies is a major component of Frontenac Paramedics' work. Paramedics have recently seen a dramatic increase in calls for suspected opioid-related emergencies. In 2019 Frontenac Paramedics responded to 91 calls for suspected opioid overdoses. In 2020 there were 121 paramedic responses for suspected opioid overdoses — representing a 33 per cent increase in calls over 2019. In the first six months of 2021, Frontenac Paramedics saw 166 suspected opioid-overdose calls. If this trend continues, it will represent a 174 per cent increase from 2020 and a 264 per cent increase from 2019.

This is an alarming illustration of the scope of the opioid crisis and the situation our community faces. These statistics only represent one snapshot of the landscape. They do not include people who presented directly to the emergency department or where naloxone was used and 911 was never activated. Increasing call volumes at this rate is not sustainable, nor is it good for the community.

An old adage from emergency management about recovering from a disaster is to "build back better." So how do we build back better following an opioid overdose? By providing trauma- and violence-informed care, anti-stigma training, access to other community resources, low-barrier housing, and ongoing supportive care.

Paramedics play an ongoing roll in some of these aspects, in the conversations they have with patients following an overdose; how they advocate for the patient; and, importantly, how the patient is treated following an overdose. If done well, these could lead to decreasing opioid overdoses in our community.

Paramedics, along with a wide array of other health-care and community personnel, have been an integral part of dealing with the opioid crisis locally. If we want to see an end to the opioid crisis, it will truly take a village to accomplish this.

We are fortunate in our community to have such a village. There are many community partners that meet regularly to address issues and develop solutions that will contribute to ending this crisis.

We should be very proud of the commitment, dedication, and accomplishments of these groups who are too numerous to mention here. It stands in testament of the kind of community we live in and the kind of community we want in the future.

Marc Goudie is Deputy Chief of Performance Standards at Frontenac Paramedics.

REFERENCES

1. Belzak, L., & Halverson, J. (2018). The opioid crisis in Canada: a national perspective. *Health Promotion and Chronic Disease Prevention in Canada: Research, Policy and Practice*, 38(6), 224–233
2. Public Health Ontario. (2021). Interactive Opioid Tool: Opioid-related morbidity and mortality in Ontario
3. Kingston, Frontenac, Lennox & Addington Public Health. (2020). Opioids
4. Gomes T, Murray R, Kolla G, Leece P, Bansal S, Besharah J, Cahill T, Campbell T, Fritz A, Munro C, Toner L, Watford J on behalf of the Ontario Drug Policy Research Network, Office of the Chief Coroner for Ontario and Ontario Agency for Health Protection and Promotion (Public Health Ontario). Changing circumstances surrounding opioid-related deaths in Ontario during the COVID-19 pandemic. Toronto, ON: Ontario Drug Policy Research Network; 2021
5. Public Safety Canada. (May 2017). *An Emergency Management Framework for Canada: Third Edition*
6. Frontenac County Council Meeting. (19 May 2021). Council Minutes

The Accidental Advocate

Barb Cahill with her son and his sister in Whistler, B.C. in 2020. This photo represents the highs and lows of recovery that Barb and her family are journeying alongside her son. Photo courtesy Barb Cahill.

By Barb Cahill

Turning the pages of an old photo album, I am reminded of birthday parties and sleepovers my son and his friends attended. Some of the young, smiling faces from these photos are now struggling with a substance-use disorder. Tragically, others are dead, their lives taken by a toxic drug supply. In 2019, several of my son's friends died from a toxic drug poisoning within a period of a few months.

How were we to know that these kids would be plucked from a fun-loving childhood in the suburbs and transported into a life controlled by addiction? People with an addiction battle the disease each and every day. Their brains have been hijacked, convincing them that their need for the drug outweighs other aspects of life such as relationships, shelter, food, the law, and even life itself. This process often arises in response to psychological trauma, emotional pain, and desires to feel better.

Understanding the physiology of addiction eludes most of us. If we take time to recognize addiction as a medical condition, as altered brain processes that result from attempts to relieve pain, we can start to reduce the stigma that prevents people who use drugs from seeking help.

"My Name is Barb, and My Son Needs Help"

My son was employed, owned his own home and car, and was in a committed relationship for over 10 years … until addiction took most of that away. In 2019, he reached out, asking for help. He was broken and humiliated, sitting at a McDonald's without a place to go or food to eat. After years of loving him from the sidelines during his active addiction, this plea for help was what I had been praying for.

This is the place where love and addiction meet — the faceoff. Help-seeking is often met with judgement from those who believe in the need for "tough love," "letting go," or "hitting bottom." When hitting bottom means death, we are now dealing with a terminal illness.

Any one of us would expect a parent to do all they can

to help a terminally ill child. However, when that illness is a substance-use disorder, the word enabling is tossed around and creates feelings of shame among people who stand by someone battling addiction. Those of us who support people who use drugs face struggling with grief — grieving someone who is still alive but is not who we knew them to be or grieving lost potential. Unfortunately, that grief is disenfranchised and often turns into anticipatory grief as we wait for the call that our loved one has died.

When my son asked for help, I believed there was a system in place that would support him into recovery. I had worked in Kingston and participated on various committees for years, so I was familiar with some of the resources and services that existed. Unfortunately, even with this familiarity, navigating the system was at times frustrating, confusing, and very lonely. The realities of service availability were in stark contrast to what I had expected. Seeking help could be overwhelming and depressing, and I was appalled at the discrimination we experienced during this time. I lost count of the number of times I said, "My name is Barb, and my son needs help."

System Shortfalls: Challenges We Encountered

Every city has a housing strategy but demand far outweighs the supply. Wait lists can be five or more years long, there aren't enough housing units, and there aren't enough case managers. Rentals may be designated for students or impose barriers such as requiring employment, references, or credit checks. Monthly motels are often full.

As I tried to help my son scrape his dignity off the floor, I walked into a motel and burst into tears. I found myself begging the manager to rent my son a room. I was told that the manager would "take a look at" my son first. The lowest rate we could find was $2,250 per month for a single room. My son has a common-law partner, and the financial assistance they received for shelter, food, toiletries, and clothing, etc., was $1,079 per month. I was informed that any money I "gifted" them to support or subsidize their housing would be deducted from their monthly allowance of $1,079. How can one be expected to thrive, let alone survive, in this kind of situation?

Beyond housing, the barriers people face in entering rehab programs are many. When a person is finally ready to enter residential treatment, the window of opportunity is short. Many treatment facilities will not accept MAT (medically assisted treatment such as methadone therapy), many insist on a full detox prior to admission, and wait lists for longer-term rehabs are at least six months. Additional assessments are needed, and if weekly calls to an answering machine are missed, one can move back down to the bottom of the wait list.

Finally, after many months of waiting, a bed became available for my son at a residential treatment program in Ottawa. He was filled with hope and excitement on the day we set off, all set with new shoes, track suit, and toothbrush. We arrived to a scene that could only be described as a war zone. As I waited to find out where to go for admission, we observed bodies surrounded by first responders, taunting shouts, and people vomiting in the hallways. We didn't stay.

I had never contemplated private treatment, but my son was very close to death and I needed to act quickly.

I knew if my son was to stay alive, he needed a chance. He needed a safe place to live.

I became my son's landlord and case manager. Housing a person with an addiction to methamphetamine and fentanyl is terrifying and not without risks. Toxic street drugs laced with contaminants such as benzodiazepines resulted in chaos and frequent overdoses.

For the next 14 months I made calls daily seeking additional support, locally and provincially. I had just about given up hope when a colleague shared her own experiences of sending her son out of country for treatment and then to New Westminster in British Columbia. I had never contemplated private treatment, but my son was very close to death and I needed to act quickly. With the generous support of family and friends, I created a fundraiser and raised enough money for a month of treatment at the Together We Can treatment centre in B.C. At this point, one day or one month of him staying alive was all I hoped for. Private treatment afforded him a bed immediately. A quick assessment over the phone and he was on his way.

As I reflected on our journey, some questions came to mind:

- Why did I need to turn to out-of-province treatment?
- In Ontario, why do we not have sober living communities that include supportive housing for singles and couples?
- Why is there not a comprehensive support plan for people released from custody?

- Why are probation officers not reaching out to a person's support network?
- Why are concerned family members excluded or dismissed?

System Improvements: How Can We Better Support People?

We know there are many roads in and out of addiction. Stigma, discrimination, and poor public policy are contributing to, if not driving, increasing death rates. Recent data shows that drug-related deaths claim the lives of 17 people per day across Canada. That's 17 people per day, every day. Individuals often suffer in a seemingly never-ending cycle of addiction, unemployment, poverty, homelessness, criminal activity, and incarceration that is all too commonly life-ending. Release from incarceration into homelessness and poverty can trigger a relapse, and the cycle continues, over and over. We, as service providers and community members, need to use every tool available to prevent loss of life.

We need to raise public awareness and, together, call for public policy change. We need cohesive, comprehensive strategies that ensure we are part of the solution. We need to overcome stigma — and in order to resolve it, we need to acknowledge it broadly. We need determination to come together and overcome the loss our community has faced and will continue to face if we don't act.

What kinds of changes can we make and where can we act? What if:

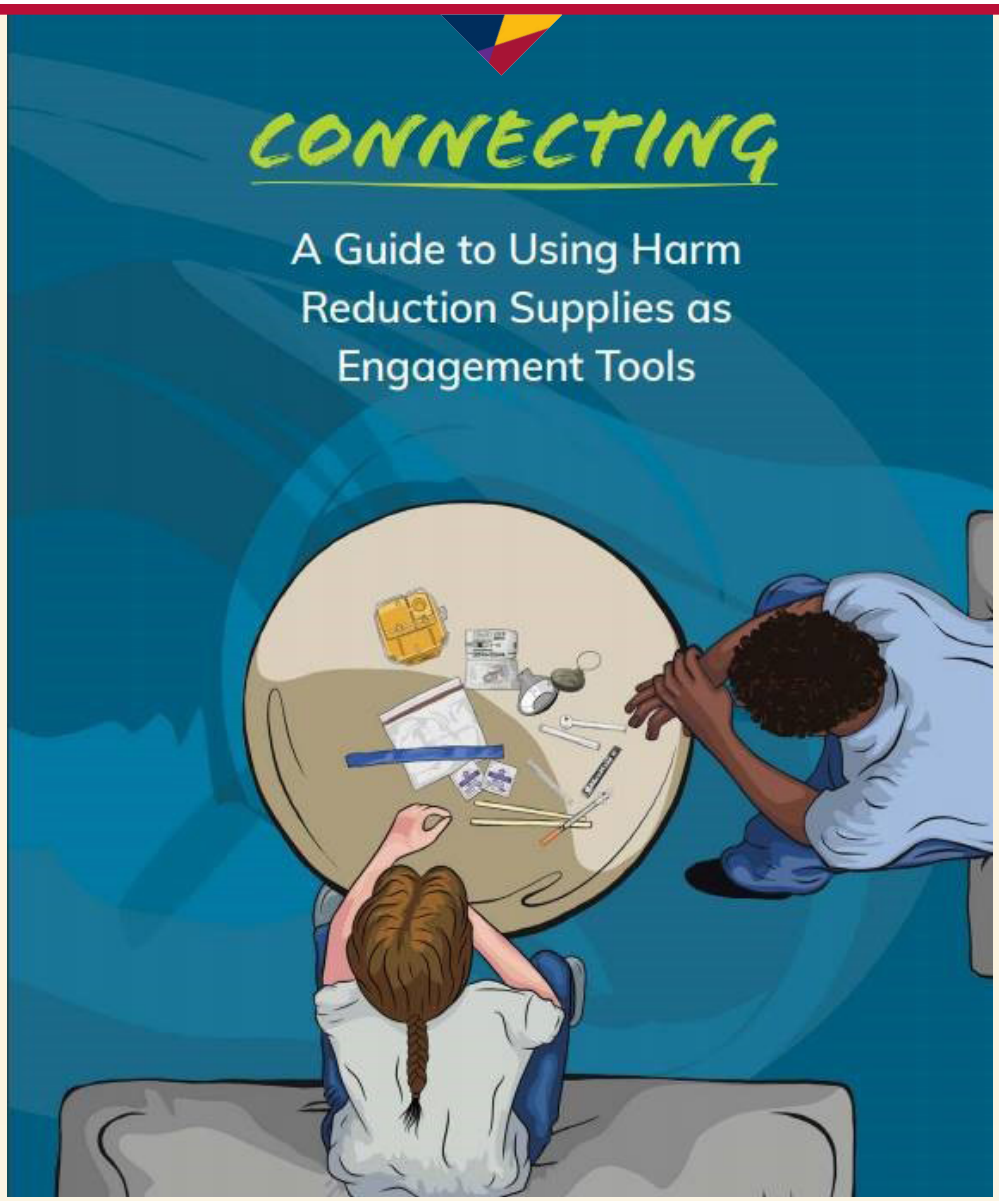
- we learned from international experience about approaches to better supporting people who use drugs;
- we decriminalize simple possession and provide a safe supply;
- we used drug poisoning/overdose events and emergency department visits as opportunities to enter treatment in the moment;
- we made treatment attractive and made sure people were informed about where they were going, for how long, and what type of care or housing they could expect afterwards to lessen their worries;
- we could offer "treatment on demand" and "housing on demand;"
- a person exiting treatment or incarceration was offered priority housing and support;
- every detention centre had a substance-use treatment facility available and accessible to anyone — one without stringent eligibility criteria only for those "at risk of re-offending;"and
- we meet people where they are and help them to lead their own recovery journey, enlisting peer supporters and recovery coaches?

It is evident there is much work to do. Fortunately, many folks are committed to advancing this work and improving systems of care for people who use drugs. While my son was in Kingston, Street Health Centre and the staff there were an absolute lifeline to us. They supported us with compassion and patience as we tried to find solutions, often thinking outside the box. They worked tirelessly and without judgement. I believe family members can help their loved ones by being informed. I became involved with the parent support and advocacy groups Families for Addiction Recovery (FAR Canada) and Moms Stop the Harm (MSTH).

My son persists in his efforts to find long-term recovery. The road is not smooth or easy and he continues to access the services of B.C.'s Together We Can. He is alive and will always have the love and support of his family.

I have become an accidental advocate. I have stepped out of the shadow of shame and stigma to tell my story in attempts to keep my son and others just like him alive.

Barb Cahill recently retired from her position supporting youth and their families at the Algonquin & Lakeshore Catholic District School Board. She is a member of the KFL&A Community Drug Strategy advisory committee and stigma & education subcommittee, and a member of the United Way KFL&A Youth Homelessness committee. Barb also volunteers at FARCanada.org as a peer supporter and is pursuing training as a recovery coach.



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Harm-Reduction Supply Teaching:
Client Engagement & Reducing Infections

By Meghanne Hicks

Addiction is a lifelong struggle. It is not something that can be dealt with in one visit to the family doctor. Addiction is understood to have severe medical-associated health complications that may persist even if the client is agreeable to or successful with rehabilitation efforts. An addiction to injectable drugs carries an even higher risk of associated medical problems such as viral, fungal, and bacterial infections that can lead to life-threatening conditions such as endocarditis, spinal abscesses, and sepsis.

A common approach to treating patients who use drugs, however, is to instruct the person to stop using drugs and/or to refer them to a clinic for Opioid Agonist Therapy (OAT), if appropriate. But could we be doing more?

Scenario:

You are treating a 32-year-old female in your clinic. She has a history of intravenous drug use (IVDU). She uses both methamphetamine and opioids daily. She was recently discharged from hospital following an admission for infective endocarditis. On this admission it was also discovered she has a recent diagnosis of hepatitis C and is following up in the community at the hep C clinic at the local community health centre. Today, she is presenting to your clinic for follow-up and management of the residual complications related to endocarditis.

What could have been done differently to potentially help this patient avoid hepatitis C exposure and a hospital admission for endocarditis?

Firstly, client engagement and patient relationship-building are going to be key to working with this patient. A patient-centred, non-judgemental approach is needed in order to work with this person. Informing the patient to stop using drugs will not be helpful in interacting with her or in building any sort of therapeutic rapport. If she is not in the right stage of change (or is pre-contemplative), an OAT clinic referral or referral to detox may not be helpful either. While it is important to communicate available treatment options, she will have to be ready to stop using drugs in order to be successful with those options. In fact, sending her to detox if she is not ready to stop using opioids could be lethal. Her tolerance to opioids will decrease while she is in detox for a few days and if she chooses to use her usual dose of opioid upon leaving the facility, she may overdose.

Using non-stigmatizing language while interacting with this person will also be helpful. Using terminology like "substance use" instead of "substance misuse or abuse" can be less demeaning. You can also try saying "people who use drugs" instead of "addicts" or "drug abusers." Refrain from using "being clean" when talking about rehabilitation efforts; "being in remission or recovery" is more sensitive and does not suggest that someone who is currently using drugs is "dirty."

It is important to go over the harms that methamphetamine and opioid use can cause, as the patient should be given the opportunity to make informed decisions regarding their health. Many people who use drugs will know drug use is harmful and they may want to stop. While convincing someone to stop using drugs immediately has proven to be difficult, if not impossible, you could make a small difference by lessening their exposure to additional factors that may increase the risk of further health complications. This is the focus of harm reduction.

A harm-reduction approach could present the opportunity to start talking with your client about some ways in which they could make their drug use safer, such as:

- not using drugs alone;
- using drug consumption sites or overdose-prevention sites if available;
- using smaller amounts to start off after periods of sobriety (including spending time in hospital or detox, incarceration, etc.);
- ensuring they carry — and understand how to use — a naloxone kit (and have friends that carry naloxone kits also);
- ensuring they have access to the National Overdose Response Service — 1-888-688-NORS (6677) — if they have access to a phone;
- doing test doses before doing a whole dose;
- using new harm-reduction supplies and ensuring they are not sharing any supplies with others; and
- ensuring they know where to obtain harm-reduction supplies and how to dispose of them correctly.

A harm-reduction approach can present the opportunity to discuss techniques your clients use and the supplies they have available to use their drugs.

A harm-reduction approach can also present the opportunity to discuss techniques your clients use and the supplies they have available to use their drugs. These could be factors that are unknowingly contributing to their exposure to infection. Questions that could be helpful could include:

- Are they using new supplies obtained from a needle-distribution program or are they using homemade equipment they sterilize themselves?
- Are they using alcohol swabs on their skin prior to injection each time they pierce the skin or are multiple pokes being made with the same needle with no attempts at cleaning?
- Are they using a cotton filter when they are drawing up their drug into their syringe to filter out debris or are they using a cigarette filter or nothing at all?
- Are they keeping used filters for later use to do a "wash" (using the filter again and rinsing it with water to release the rest of the drug that is trapped inside the filter for an additional dose)?
- Are they sharing equipment with others? Are they dipping into the same cooker or spoon while sharing drugs with others?
- Are they always using sterile water to mix up their drugs or are they using tap or toilet water?
- When heating a drug to dissolve and "cook" it, are they letting the solution in the cooker cool before

injecting it or do they draw it up right after it boils and inject it into their veins while it is still hot?

- Are they rotating injection sites, or do they always use the same site?
- What is their preferred location to inject? Why? Are they aware of safer injecting locations?
- Do they inject their own drugs? If not, who would usually do it for them and why?
- Are they familiar with the difference between an artery and a vein?
- Are they injecting with the bevel of the needle facing up or down?
- Are they having sexually transmitted infection/blood-borne infection testing done every three months while actively using drugs?
- Are they practising safe sex (since stimulants are known to increase libido)?

All of these questions are important in assessing the additional level of risk in which someone may unknowingly be engaging. However, this is by no means a comprehensive list. You will ultimately come to know the client's level of awareness for their risk for infection if they are willing to answer the questions truthfully.

If the client is poking themselves many times in the same spot, poking themselves with the bevel of the needle facing down, or using the same needle many times, they may be doing unnecessary damage to their veins. This will lead to scarring and render the vein unusable in the future for hospital visits or further drug use. They may consequently seek out riskier venous access areas in which to inject.

If a client is choosing to do a "wash," they may be keeping the wet filter in a package for multiple hours/days in a backpack or purse and this practice risks microbial growth that will then be injected into the person at their next time of use.

Perhaps your client is having someone else inject their drugs for them because they are unsure how to properly inject. Your client is now not in control of their own drug use and it may put your client in a position of dependence on another person. Perhaps some teaching could help them become independent with their drug use and less reliant on someone they may not know or trust.

Perhaps your client is not injecting at all and their preferred method of using their drug of choice is inhalation or snorting. Clients risk passing blood-borne viruses, specifically hepatitis B and C, by sharing pipes and stems to snort or smoke.

Offering instructions on the proper use of harm-reduction supplies for drug use can keep your patient safer when they use drugs. Encouraging safe-use techniques while being mindful that their drug use may not be perfectly sterile or in a clean environment every time (e.g., using in bathrooms or outdoors) could encourage them to make safer choices and may even change their drug use routines in the future.

While we have no control over what is mixed into the drugs these individuals are using, we can assist to eliminate additional harms by giving some instruction on proper technique and proper use of supplies to assist in controlling their exposure to harmful micro-organisms that may be found on the skin or from using used or contaminated equipment.

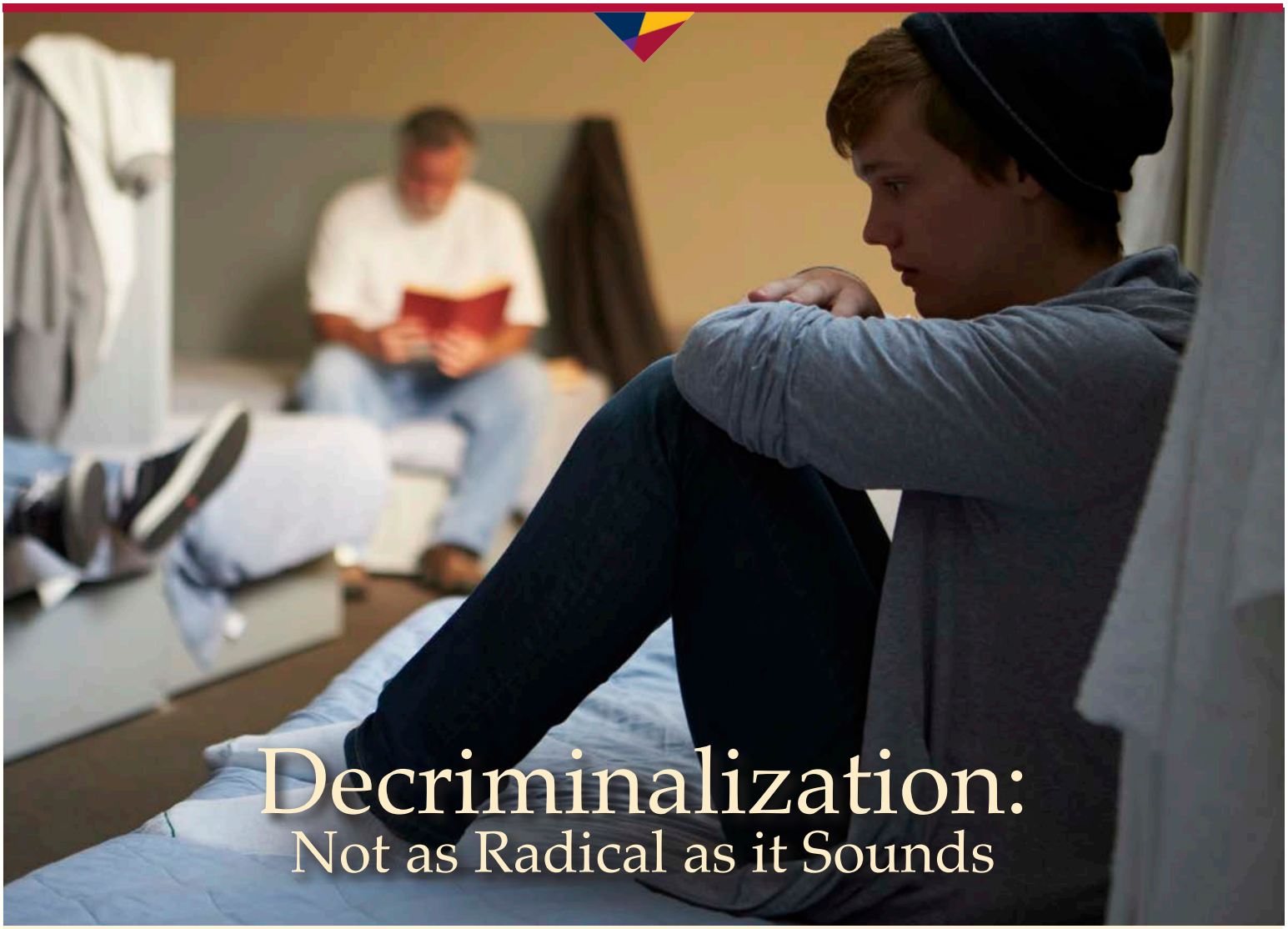
While we have no control over what is mixed into the drugs, we can assist to eliminate additional harms by giving some instruction.

If you are interested in learning more about using harm-reduction supplies as a means for client engagement, please refer to Connecting: A Guide to Using Harm Reduction Supplies as Engagement Tools,[1] produced by the Ontario Harm Reduction Distribution Program (OHRDP).

If, within your practice, you find you are interacting with people who use drugs, please become more familiar with discussing methadone, Suboxone, and other forms of OAT to support those who use opioids and who are ready to reduce or stop using drugs. Become familiar with the OAT and RAAM (Rapid Access Addiction Medicine) options in Kingston. Start prescribing or distributing naloxone kits and become trained on providing teaching on how to use them. Visit the OHRDP website to learn the location of local harm-reduction distribution sites for picking up supplies and disposing of used supplies. And, finally, read through the "Connecting" guide to become more knowledgeable about safer drug-use technique.

Meghanne Hicks, BScN RN, is a Concurrent Disorder Specialist, PSR ACTT, at Providence Care in Kingston.

1. Miskovic, M., Zurba, N., Beaumont, D., Conway, J. (2020). Connecting: A Guide to Using Harm Reduction Supplies as Engagement Tools, Ontario Harm Reduction Distribution Program, Kingston Community Health Centres, Kingston Ontario



Decriminalization:
Not as Radical as it Sounds

By Dr. Jane Philpott

Deidra Garrah died on March 10, 2020, just before Ontario went into lockdown due to COVID-19. At just under 18 years old, she died alone in Ottawa, of acute fentanyl toxicity. Deidra came from a loving family in Verona, north of Kingston. After years of struggling with mental health issues and unsuccessful psychiatric interventions, she was living on her own and had become dependent on substance use.

Deidra's death happened at the beginning of what many are calling a shadow pandemic — the dramatic increase in deaths due to opioid use in Canada, which has been underreported since COVID-19 started dominating headlines. Though Deidra's death came at the start of this upswing, her experience is not unique. Kingston has had an increase in hospitalizations associated with fentanyl. Police and public health have been warning about an increase in highly toxic illicit drug supplies.

Deidra's family has stated that they want people to remember her not as a number in a set of statistics, but as a person who was cared for and loved by her family and friends.

In 2020, on average, 17 people died in Canada every day from an opioid-related overdose. Fourteen people were hospitalized each day. From April to December 2020, the first nine months of the COVID-19 pandemic, 5,148 people in Canada died from opioid-related overdoses. That's an 89 per cent increase from the same time frame the year before.

The public health discourse of the last 18 months has been focused on COVID-19, and for good reason, but there is less attention on the fact that we were already dealing with another national public health emergency.

Not only are opioid-related deaths among the top 10 causes of mortality in our country, but the number grows each year. The likelihood of death from overdose is higher than ever because illicit — otherwise known as "street" — drugs are increasingly contaminated with fentanyl and its analogues, contributing to 82 per cent of accidental opioid-related deaths in Canada. This translates to an estimated one million Canadians who are at risk of exposure to toxic opioid products.

This is not something we can turn away from, nor does it only affect structurally marginalized people. The people

the crisis affects are our relatives and neighbours. People use drugs in city centres but also in suburbs, small towns, and remote regions; they use drugs in urban areas, but also alone at home or in unseen public spaces. If you don't already know someone who has lost a loved one because of an accidental opioid overdose, it's only a matter of time until you will.

Whereas government, public health, and community leaders worked together in a co-ordinated way to address the COVID-19 pandemic, there has been a complete absence of co-ordination — let alone discourse — around the opioid crisis.

This is possibly because the solutions to the crisis are politically unpopular. The way out is difficult to explain, and few are ready to push for it. But, if every life is of value, then it's time to get beyond our prejudices and political biases. Policy-makers need to implement the steps that will save lives.

In the last six years, Canada has made some progress on drug policy. Naloxone, a drug that temporarily reverses the effects of opioids, became available without prescription and in multiple forms in 2016. Bill C-37 was passed in 2017, reintroducing harm reduction and facilitating approval of supervised consumptions sites. The same year, a ban on use of prescription heroin for people with substance dependence was overturned, enabling a path for bulk imports.

We must do more. Following Portugal's lead, Canada should decriminalize the possession of small amounts of drugs — a 10-day personal supply.

Decriminalization sounds radical, but it is not. It is essential for turning the tide on opioid-associated mortality.

Addiction is not a crime. It is not weakness or moral failure. Public policies related to people who use drugs are matters of health and social justice. Problematic drug use is driven by poverty, trauma, stigma, isolation, and abandonment. Moreover, there is no single story. Canadians from all walks of life participate in high-risk substance use, for a variety of reasons.

There are those who suffer from chronic pain or insomnia, or post-traumatic stress disorder; and victims of violence or sexual trauma. There are people with anxiety disorders or chronic depression who self-medicate to manage intolerable symptoms. There are others with undiagnosed attention deficit hyperactivity disorder (ADHD) who turn to stimulants to help them focus.

Regardless of the reason for using opioids, there is always the risk that a person may inadvertently become dependent and end up in a situation that triggers the pursuit of illicit, and possibly toxic, drugs.

To see the value in decriminalization, we need to reframe our perception of problematic substance use. We must see that it is a highly complex issue. We can't solve a health and social issue by criminalizing those who suffer. This has been tried for decades and has been a complete failure.

Addiction is not a crime. It is not weakness or moral failure. Problematic drug use is driven by poverty, trauma, stigma, isolation, and abandonment.

In the case of opioids, criminalization has never effectively reduced drug use. Instead, criminalization sparks a series of consequences that rarely help the individual, let alone promote public interest. That's because the criminal justice system does not meet the most pressing needs of people who depend on substance use. While incarceration may temporarily achieve abstinence from drug use in a controlled environment, it provides no guarantee of long-term abstinence. Nor does it eliminate the complex underlying health and social conditions that lead to substance use in the first place.

What individuals need, instead, is access to health and social solutions: therapeutic interventions, affordable housing, healthy food, employment services, companionship, and mental-health supports. Where there is a shortfall in the services needed to restore well-being, criminalization is not the answer.

In 2001, Portugal decriminalized all drugs. Their objectives were to reduce discrimination and emphasize the inalienable human dignity of all citizens. They brought together experts in medicine, law, and social work to design a health-centred drug policy. The country's resources are focused on social services and re-integration rather than the criminal justice system.

Portugal's approach reminds me of how First Nations writer and residential school survivor Edmund Metatawabin describes the word "justice" in his book *Up Ghost River*. While there is no Cree word for justice, he says "the nearest word is 'kintohpatatin,' which loosely

Canada is perfectly positioned to be a global leader by doing what works — prevention, treatment, harm reduction, and decriminalization.

translates to 'you've been listened to' … Kintohpatatin is richer than justice — really it means you've been listened to by someone compassionate and fair, and your needs will be taken seriously."

When confronted with people possessing small amounts of drugs, Portugal's model is to take health and social needs seriously. It improves lives and directly addresses the drivers of dependency.

A longstanding hotspot in the opioid crisis, B.C. had a record-breaking 176 deaths in the month of April 2021. The province's lower mainland regions have been most impacted by overdoses, especially Vancouver and Surrey. It is with urgency that Vancouver has made a bid to be the first city in Canada to decriminalize the possession of small amounts of illicit drugs. The bid was made through a request for the federal government to grant an exemption to the criminal prohibitions that make it illegal to possess controlled substances. If granted, the exemption would essentially decriminalize the possession of a small supply of drugs. The exemption would be limited to the "simple possession" of drugs like heroin and meth.

Within the provisions of the Controlled Drugs and Substances Act, Federal Health Minister Patty Hajdu has broad power to grant this exemption if she believes it is in the public interest.

Every paradigm shift in drug policy is politically and emotionally charged. That must not deter us, because opioid-associated deaths can be prevented. Canada is perfectly positioned to be a global leader by doing what works — prevention, treatment, harm reduction, and decriminalization.

Now is the time for the health minister to do what's right and decriminalize the possession of small amounts of substances — not only in Vancouver, but throughout the whole country.

The Honourable Dr. Jane Philpott is Dean at the Faculty of Health Sciences at Queen's University and former Federal Minister of Health and Minister of Indigenous Services.

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