“MAKE NO MISTAKE, PEOPLE ARE DYING”: A LITERATURE REVIEW OF THE OPIOID CRISIS IN CANADA

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Abbreviations

Abbreviation	Definition
APH	Algoma Public Health
CDPC	Canadian Drug Policy Coalition
CMHA	Canadian Mental Health Association
CTS	Consumption Treatment Services
DTES	Downtown East Side
NIMBY	Not in My Backyard
OPS	Overdose prevention site(s)
PHO	Public Health Ontario
PHAC	Public Health Agency of Canada
SCS	Supervised consumption site(s)
SDH	Social Determinants of Health
SIS	Safe injection site(s)
THRA	Toronto Harm Reduction Alliance
TOPS	Toronto Overdose Prevention Society
VCHA	Vancouver Coastal Health Authority
VANDU	Vancouver Area Network of Drug Users

Abstract

Objective: Evidence has indicated that harm reduction practices aid in preventing drug overdose and provide social support for people who use drugs. However, less is known about the enablers and barriers to adopting such practices in public health policy. The purpose of this research is to investigate how social and political factors act as enablers or barriers to implementing harm reduction services, with a focus on the roles of activism and evidence-based research.

Design: A policy and history analysis of the opioid crisis in Canada, with a focus on British Columbia and Ontario.

Methods: I conducted a literature review of published literature, grey literature and Federal and Provincial government reports.

Findings: My findings demonstrate that activism is a stronger enabler for harm reduction than evidence-based research in both Ontario and British Columbia. A common barrier in Ontario is the difference in political values between the provincial and Federal governments. Also, limited funding and poor resource distribution resulted in equity concerns for Northern communities like Sault Ste. Marie.

Conclusions: My findings emphasize the need for a more equitable reallocation of Provincial funding for mental health and addictions health care. A shift in political values may enable Ontario to implement harm reduction services long-term. More research is needed to better understand the intersection of multiple social determinants of health.

Introduction

Background Information

The opioid crisis has been an ongoing public health threat in Canada since 2016, affecting the lives of people who use drugs, their families and friends, and communities nationwide (PHAC, 2023a). Data from the Public Health Agency of Canada (PHAC) indicates that from January 2016–September 2022, there were 34,455 opioid toxicity deaths, 94% of which were accidental overdoses (PHAC, 2023a). In 2017, there were approximately 11 opioid-related deaths per day, which increased to 21 in 2021 (PHAC, 2023a). This rate continued to increase, and from January–September 2022, there were approximately 20 deaths per day, totaling 5,360 in the span of four months (PHAC, 2023a). In addition to the alarming mortality rates, data shows that opioid-related hospitalizations were also elevated in recent years, with 34,866 occurring from January 2016–September 2022 (PHAC, 2023b). From January–September 2022, there were a total of 3,917 opioid-related hospitalizations, with a rate of 14 per day (PHAC, 2023b). As evidence indicates, many jurisdictions reported elevated opioid-related hospitalizations and deaths, suggesting the opioid crisis was exacerbated by the COVID-19 pandemic. Overall, Canadians ages 20–59 represent the majority of accidental opioid overdoses nationwide, but youth ages 15–24 are the most vulnerable group, representing a majority of hospital visits resulting from opioid overdose (Government of Canada, 2020).

The opioid crisis is a multidimensional issue, as the increase in opioid-related overdose is likely caused by both increased toxicity of illegal drug supply and increased

rate of pharmaceutical opioid prescribing[1] (Government of Canada, 2020). Illegal street drugs are now often laced with toxic opioids like fentanyl, which can be fatal with only a 'grain of salt' amount (Government of Canada, 2020). Evidence indicates that fentanyl-containing street drugs continue to be the primary contributing factor, as 81% of opioid-related deaths from January–September 2022 involved fentanyl, and 78% involved other non-pharmaceutical opioids (PHAC, 2023a). During the same timeframe, fentanyl or fentanyl analogues were involved with 31% of opioid-related hospitalizations (PHAC, 2023b). 31% of accidental hospitalizations involved fentanyl, compared to 18% of opioid poisonings, highlighting its potency and threat to public health (PHAC, 2023b).

PHAC notes that a majority of opioid-related deaths and hospitalizations have occurred in British Columbia, Ontario, and Alberta (PHAC, 2023b). From January–September 2022, 87% of accidental opioid-related deaths and 88% of hospitalizations occurred in these provinces (PHAC, 2023a). General stimulant-related hospitalizations were highest in British Columbia, the Territories, Saskatchewan and New Brunswick (PHAC, 2023b).

In this paper, I conducted a history and policy analysis of the opioid crisis in Canada, focusing on British Columbia and Ontario. By comparing the ways each province addressed the increase in opioid-related harms, I hoped to gain a better understanding of the social and political factors that influence policy making.

[1] Through lobbying lawmakers and funding medical organizations, Purdue Pharma promoted opioids as safe pharmaceuticals with a low risk for addiction (Deweerdt, 2019). By the mid-1990s, OxyContin prescriptions to treat chronic pain increased considerably, primarily targeting white suburban communities (Deweerdt, 2019). In the Canadian context, Purdue Pharma Canada has been involved in several class-action lawsuits, including the 2018 lawsuit against British Columbia (British Columbia Attorney General, 2022). The proposed settlement was $150 million to recover healthcare costs caused by opioid-related damages nationwide (British Columbia Attorney General, 2022).

Specifically, what are the enablers and barriers to adopting a harm reduction approach in public health policy? Due to the multidimensional nature of the opioid crisis, using social determinants of health (SDH), political economy, Mad studies, and health equity lenses provides an opportunity to analyze the crisis from various perspectives, highlighting the social, political and environmental factors that are at play. In addition to published literature, I also consulted grey literature, public health statistics and federal and provincial policies to determine the enablers and barriers of harm reduction implementation. In the final section, I concluded with a summary of my findings, and proposed suggestions for future research, policy and practice.

Reflexivity

Reflexivity is a type of reflection tool that enables us as researchers to challenge our assumptions of a topic, and consider how these assumptions exist within the broader social and political context (Alley et al., 2015). Personal values, beliefs and experiences are often incorporated in the research method, so practicing reflexivity allows us to be critical of our bias in the research we use and produce (Alley et al., 2015). As a result, new insight on the research topic is generated (Alley et al., 2015).

I was born and raised in Sault Ste. Marie, a city in the Algoma region in Northern Ontario. Over the years, I have witnessed the opioid crisis continue to worsen, as more people in my city lose their lives due to opioid poisoning each week. The stigmatization of addictions and opioid use is prevalent, and the lack of mental health and addictions support services is concerning. During the summers of 2021 and 2022, I worked as a

summer student in the Infectious Diseases and Immunizations departments at Algoma Public Health (APH). I prepared harm reduction kits with sterile drug paraphernalia, along with information pamphlets about safe drug use, and HIV and overdose prevention. I also scheduled COVID-19 immunization appointments for patients residing in Algoma. Oftentimes there was a lack of sterile drug paraphernalia, so we were unable to provide kits at the walk-in clinic for people who use drugs. Similarly, the lack of COVID-19 vaccines meant that some individuals were unable to receive their immunizations when they were eligible. So, although my experiences in these two departments differed in the day-to-day tasks, they were linked together by my overall concern for the lack of essential healthcare resources. Through these experiences, I came to realize that smaller communities like Sault Ste. Marie are rarely prioritized when it comes to the distribution of healthcare resources. This equity concern, the demand for help, and the alarming rates of overdose in Sault Ste. Marie inspired me to become an advocate for change.

Harm Reduction

To combat the harmful effects of opioid use, Canada has adopted a harm reduction approach in the *Canadian Drugs and Substances Strategy* (Government of Canada, 2016a). The Canadian Mental Health Association (CMHA) (2023) describes harm reduction as an evidence-based and client-centred approach to supporting those experiencing addictions and substance use challenges (CMHA, 2023). Different from other forms of addictions treatments, harm reduction does not make abstinence from substance use the only end goal, as it recognizes that addiction is a complex issue

(CMHA, 2023). Sometimes, individuals are not in a position to abstain completely, so instead, harm reduction prioritizes overall safer and healthier living by providing a variety of different programs and services (CMHA, 2023). This approach encourages medical and social services staff to "meet [service users] where they are" in a non-judgemental and non-coercive form of support (CMHA, 2023, n.p.). Importantly, harm reduction philosophy supports a health promotion approach by empowering individuals to make their own informed choices about which services and strategies they will use to minimize the harmful effects of their substance use (CMHA, 2023; Whitehead, 2004). Evidence has indicated that encouraging patient empowerment supports long-lasting engagement in harm reduction services (CMHA, 2023). Harm reduction philosophy and programmes are supported globally by the World Health Organization (WHO) and the United Nations office on Drugs and Crime, and UNAIDS as a viable approach to alleviating substance use and addictions challenges (CMHA, 2023).

Overdose prevention sites (OPS) are a common form of harm reduction to support people who use drugs. Similar locations include safe injection sites (SIS) or supervised consumption sites (SCS). In addition to providing a safe and hygienic environment for drug consumption with medical supervision, these sites employ a variety of other services, including sterile drug supplies, health education, drug treatment referrals, food banks, and income and housing support services (CMHA, 2023; Government of Canada, 2018). Research shows OPS (and their analogues) prevent HIV and Hepatitis C, reduce the economic burden of substance use on the health care system, and most importantly,

prevent drug-related overdoses and deaths (CMHA, 2023; Government of Canada, 2018). Moreover, contrary to public belief, OPS do not increase crime and precarious public consumption, but rather reduce it (CMHA, 2023). Overall, these sites provide a comprehensive approach to mitigating the harms of drug use, especially opioids during the opioid crisis.

Although these sites essentially provide similar services, there are notable differences between SCS and OPS. SCS have been exempted from section 56.1 of the Health Canada *Controlled Drugs and Substances Act*, meaning that anyone using their own drugs at these facilities will not be prosecuted for drug possession (Pivot Legal Society, 2021). Unfortunately, it is challenging and time-consuming to implement SCS due to the bureaucratic burden (Pivot Legal Society, 2021). To avoid this burden, OPS have opened up in the interim as a grassroots community-based approach to combat the alarming rates of drug overdose (Pivot Legal Society, 2021). They originated in British Columbia as pop-up locations (often in public parks) and are usually run by peers with drug use experience (Pivot Legal Society, 2021). These communities were committed to creating safe spaces for drug use long before the government intervened to provide support (Pivot Legal Society, 2021). Thanks to their ongoing commitment, now the Minister of Health in British Columbia considers these sites to be emergency health services and ensures they are available province-wide (Pivot Legal Society, 2021). These sites are usually basic, low-barrier locations that do not require an exemption from Health Canada to operate (Pivot Legal Society, 2021). Some OPS even allow drug inhalation as a form of consumption which is sometimes prohibited at SCS (Pivot Legal Society,

2021). Although less official than SCS, they still provide similar harm reduction services (Pivot Legal Society, 2021).

Evidence indicates harm reduction practices have been shown to prevent drug overdose and blood-borne illnesses through the use of medically supervised OPS (CMHA, 2023). Supported world-wide, this approach acknowledges the complexity of drug use, and encourages drug users to make an informed choice about treatments and interventions (CMHA, 2023). Overall, harm reduction practices promote safer and healthier living for people who use drugs (CMHA, 2023). Despite this evidence, there are still barriers to harm reduction uptake as an approach to ameliorate the opioid crisis in Canada. Berrigan & Zucchelli (2022) conducted a study about public opinions on SCS and opioid use. Their findings revealed that participants had a strong negative response to SCS placing an economic burden on the healthcare system, however, they did not have a strong positive response to the sites lessening the economic burden (Berrigan & Zucchelli, 2022). Therefore, they suggested that the public requires more transparency about how these costs will be reduced in order for them to possibly support SCS implementation in their communities (Berrigan & Zucchelli, 2022). In addition to the economic cost-benefit analysis, Smith argues that we should also consider the social costs of implementing harm reduction programs (Smith, 2012). For example, harm reduction research conducted by Sharp et al., (2020) revealed that a common barrier to syringe exchange programs was the "not in my backyard" (NIMBY) mentality (p. 515).[2] Many members of the community rejected harm reduction programs with the fear that it would

[2] NIMBY refers to when residents in a community feel that a new development would be unwanted or inappropriate in their neighborhood (Homeless Hub, 2021).

increase drug use and pollute the neighborhood with criminal activity (Sharp et al., 2020). Sharp et al's (2020) research revealed the placement of syringe exchange programs is heavily influenced by the social and political ideologies of the community, and their upkeep is usually dependent on grassroots organizations and activists. In this sense, Smith argues it may be best for harm reduction interventions to be institutional to reduce public safety concerns (Smith, 2012). He notes an interesting ethical conundrum: "whose harm does harm reduction policy seek to mitigate and reduce, that of the drug/service user or the social body politic?" (Smith, 2012, p. 210). Therefore, this brief overview of some current literature shows that some may be against a harm reduction approach due to concerns about economic impact on the healthcare system and stigma against drug use in the community.

Brief History of Canadian Drug Policy

According to the Canadian Drug Policy Coalition (CDPC) (2023), controversial opinions about addictions and drug use in Canada dates back more than five centuries ago. During colonization in the 1500s, European missionaries and fur traders from Britain and France brought alcohol to Canada and exchanged it at trading posts (CDPC, 2023). Moral reformers were against alcohol consumption, which sparked the prohibition of alcohol and the Canadian Temperance Movement in the 1800–1900s (CDPC, 2023). Protestant Christians believed that alcohol use was immoral and corrupt, and used these beliefs to control those deemed to be a threat to European supremacy during the colonization periods (CDPC, 2023). As such, moral reformers forced their Christian

values and alcohol sobriety on communities of Indigenous Peoples (CDPC, 2023). In addition to the Temperance Movement and alcohol prohibition, drug prohibition is also linked to colonization in Canada (Boyd, 2017). In the 1700–1800s, many worldwide used psychoactive substances (e.g. opium) as a medicine for pain management (CDPC, 2023). Even though these substances were legal in Canada at the time, public opinions on their use changed as Protestant values continued to influence colonial discourse (CDPC, 2023). The Protestants believed that drug consumption threatened purity and sobriety, thus opium was seen as a threat to the lives of white, middle class communities (CDPC, 2023).

Smoking opium became more common in China in the 1700s and 1800s when the British East India Company began importing it to trade for tea (Boyd, 2017). When China attempted to end the opium trade, England fought two Opium Wars (1839–1842 and 1856–1860) against China for its continuation (Boyd, 2017). As a result of the Opium Wars, British, Canadian and U.S. Christian missionaries began to associate opium smoking with non-white people (Boyd, 2017). This shift in narrative caused drugs to be viewed as a threat to society and health, which shaped anti-drug policies and laws that we still have today (CDPC, 2023).

During the 1880s, many Chinese men immigrated to Vancouver to work on the Canadian Pacific Railway (Boyd, 2017). At the time, colonialist beliefs had already poisoned Vancouver with anti-Indigenous racism, and as more Chinese men continued to immigrate, anti-Chinese racism became more common (CDPC, 2023). The Chinese rail workers smoked opium for pain relief, and employment opportunities were scarce due to

the economic downturn (Boyd, 2017). The combination of these two factors caused Christians to feel threatened by the Chinese, resulting in a new wave of anti-Chinese racism in Canada (CDPC, 2023). In 1907, white laborers protested against the Chinese rail workers, which caught the attention of William Lyon Mackenzie King (CDPC, 2023). King later passed the *Opium Act* in 1908, signaling the beginning of drug criminalization at the Federal level, and prohibiting the manufacturing, selling and importation of opium for non-medical purposes (CDPC, 2023). By 1921, King had passed the *Opium Narcotic Drug Act*, and created the Narcotic Division of the Federal government, allowing the Royal Canadian Mounted Police to enforce drug laws nationwide (Boyd, 2017).

As time passed, injecting heroin and morphine, and smoking marijuana became more common, especially during the 1960s (CDPC, 2023). The 1960s was known as the decade of "sex, drugs and rock 'n' roll" yet also a notable time for social and political reform under John Diefenbaker's Conservative government (Boyd, 2017, p. 108). In 1961, Diefenbaker enforced the *Narcotic Control Act* which legalized discrimination against drug users, and also signed the *Single Convention on Narcotic Drugs* which enforced criminalization of substance use (Boyd, 2017). Pharmaceutical drug use also became popularized during the 1960s, but political focus was still on the criminalization of illegal substances (CDPC, 2023). In 1971, John Munro, Canada's Minister of Health, attempted to pass Bill S19 which would have legalized marijuana and removed it from Diefenbaker's *Narcotic Control Act*, however, law enforcement opposed, thus criminalization of marijuana use continued (CDPC, 2023). In 1997, the *Narcotic Control Act* was replaced by the *Controlled Drugs and Substances Act*, yet, this new Act was still

rooted in neoliberal and prohibitionist values (CDPC, 2023). In the mid-1990s, people who use drugs advocated for harm reduction and evidence-based treatments as opposed to traditional abstinence-based treatments, which started a new wave of harm reduction activism in Canada that is still ongoing today (CDPC, 2023). This brief summary of the history of Canadian drug prohibition underlies the origins of "Canada's drug laws [which] are based on racial, class and gender prejudices [...]," allowing us to reflect on the influence of politics, laws, attitudes, and moral reformers on drug policy making in the past and the present (Boyd, 2017, p. 2; CDPC, 2023).

Guiding Frameworks

This research will be guided by an SDH framework that considers the impact of social, political, environmental and economic factors on the opioid crisis and the uptake of harm reduction as a mitigation strategy. Due to its complex nature, analyzing the opioid crisis through this lens provides a chance to understand how these determinants are linked and ultimately influence harm reduction policy nationwide. In addition to the SDH, I will also employ a political economy lens to better understand the political and economic barriers of implementing harm reduction practices in Ontario and British Columbia. It is evident that the public stresses concern for the economic burden of implementing such practices. Also, understanding the political ideologies of the British Columbia and Ontario governments will be helpful when analyzing harm reduction and drug policy. Next, the Mad studies framework originates from the lived experiences of Mad people, and provides a theoretical base for understanding how mental health and

addictions were understood in the past during times when psychiatry was the dominant model of care. Although Canada has undergone the process of deinstitutionalization over the last 60 years, some beliefs, values and stigmas still influence mental health policymaking today. Finally, I will also consider the concept of health equity and how it relates to resource allocation and accessibility to harm reduction services, especially in Sault Ste. Marie.

Social Determinants of Health

PHAC describes SDH as personal, social, economic, and environmental factors that influence health at both the individual and community level (PHAC, 2022). More specifically, these factors include: income, social status, employment, education, childhood experiences, access to health care, genetics, gender, and race (PHAC, 2022). Identifying characteristics like gender, sexuality, and race may be related to experiences of racism, discrimination, and historical trauma which are especially prevalent in minority populations such as LGBTQ+, Indigenous Peoples and People of Colour (PHAC, 2022). Health inequalities occur when there is a disparity in health between different groups and individuals (PHAC, 2022). Although individual behavior has an influence on health inequalities, they are more commonly influenced by the uneven distribution of the SDH (PHAC, 2022).

Raphael conducted a (2011) discourse analysis of the SDH and found that although SDH are acknowledged as a contributing factor to health inequalities, they are not embedded in Canadian public policy. He argues that applying the SDH concept

conflicts with the current welfare state's model of upholding the marketplace (Raphael, 2011). So, because profit making is prioritized over health, the government now provides less financial support to maintain the health of its citizens, and at the same time income inequalities are continuing to increase (Raphael, 2011). As a result, food, housing, and employment insecurity are now common amongst other SDH disparities (Raphael, 2011). Importantly, income is a determinant of health itself, but also strongly influences the other determinants like childhood experience, education, employment, food security and housing quality (Raphael, 2011). Research indicates that having a low socio-economic status is associated with increased risk of disease and overall poorer health compared to those with high socio-economic status (Raphael, 2011).

In addition, evidence shows that experiencing multiple SDH disparities (such as low income, low education and poor employment) contributes to a higher incidence of health and social issues (Raphael, 2011). Therefore, Raphael argues that public health has a responsibility to attend to the social and healthcare needs of populations experiencing multiple SDH disparities, especially for vulnerable groups like immigrants, refugees and homeless individuals (Raphael, 2011). Overall, it is clear that as the inequitable distribution of the SDH continues, more and more Canadians suffer adverse health consequences (Raphael, 2011). Raphael's analysis revealed that these inequities occur at the fault of poor public policy making, so, it is evident that policy reform is needed to ensure equitable SDH distribution in Canada, which may decrease the SDH disparities and improve overall population health (Raphael, 2011).

Moreover, Raphael (2011) provides a critique of the SDH and the common 'healthy lifestyles' discourse in public health, which suggests individuals' behavioral and medical risk factors are connected in a causal relationship. He suggests in this discourse, it is assumed the individual is completely responsible for their behaviors and thus poor health outcomes, failing to recognize the impact of our living and working environment on our lifestyle (Raphael, 2011). It is evident that these conditions act as the main determinants of health—not our individual behaviors (Raphael, 2011). Overall, Raphael's SDH research is important to consider when analyzing a complex public health issue such as the opioid crisis. Individuals experiencing addictions challenges may be experiencing multiple SDH disparities like homelessness and food insecurity further contributing to their poor mental health. Therefore, using an interdisciplinary framework such as the SDH will be beneficial when analyzing the opioid crisis as it may highlight other health disparities and inequities in Canada. This, in turn, provides a chance to analyze policy and make suggestions for long-term change.

Political Economy

In addition to the SDH, I will also use a political economy framework to support and guide my research on the opioid crisis. It is important to acknowledge the role the welfare state plays in policy making and resource distribution. Economic and political structures influence how a nation prioritizes or neglects the SDH in their public policy, which controls their quality and distribution nationwide (Raphael, 2011). Despite being a developed nation with universal healthcare, Canada is still lagging behind in their mental

health care policies, system and delivery (Wiktorowicz et al., 2020). Following the psychiatric deinstitutionalization movement in the 1960s and 1970s, Ontario developed community-based mental health services, however, they were underfunded and thus unable to meet the needs of the discharged patients (Wiktorowicz et al., 2020). More than five decades later, this issue is still prevalent, as many Ontarians lack both the quantity and quality of mental health care they require (Wiktorowicz et al., 2020). A common barrier faced by patients is the lack of integrated mental health services (Wiktorowicz et al., 2020). The connection between primary care and community mental health and substance use services (MHSU) is inadequate, making it challenging for patients to access MHSU through their physicians (Wiktorowicz et al., 2020). In addition to the convoluted nature of the mental health care system, not all have fair access to MHSU. For example, those with health insurance coverage from their employer may have quicker access to services than those without stable income, creating an unjust "two-tiered" system (Wiktorowicz et al., 2020, p. 3). The *Canada Health Act* establishes which health care services are publicly funded, and the criteria that each province must meet in order to receive Federal funding under the *Canada Health Transfer* (Government of Canada, 2004). Only "medically necessary" mental health services are publicly funded under the *Canada Health Act* (1984), demonstrating how the Act favors the medical model of care (i.e. psychiatry) over community-based mental health care (Wiktorowicz et al., 2020, p. 3). Despite recommendations from the Mental Health Commissions of Canada and provincial policy reports, there has been an overall lack of support from both levels of government to develop a comprehensive mental health care system (Wiktorowicz et al.,

2020). Therefore, the intergovernmental structure of Canada's health policy making makes it challenging to establish a comprehensive mental health care system that meets service needs of all Canadians (Wiktorowicz et al., 2020). Considering the role of the welfare state in mental health policy making may provide a deeper understanding of mental health care service delivery amid the opioid crisis.

Mad Studies

In addition to SDH and political economy frameworks, I will also analyze the opioid crisis and addictions through a Mad studies lens. In the (2013) book *Mad Matters,* Menzies et al. examine Mad studies activism, communities, and social movements, along with anti-psychiatry and mental illness discourse. For decades, Mad people were under the domination of the medical model of care, specifically the psychiatric system (Menzies et al., 2013). Overtime, Mad activists and allies fought against psychiatry and Big Pharma to create a Mad community—a safe space free from the pathologization of mental illness (Menzies et al., 2013). As the dominant model of care has been challenged and shifted overtime, societal views of Madness and mental health/illness are continuing to change (Menzies et al., 2013). Mad studies recognizes the need for a holistic approach for "people experiencing mental anguish" (Menzies et al., 2013, p. 2) which considers how the SDH influence mental health. Due to its interdisciplinary method, Mad studies addresses a wide scope of politics, such as "anti-poverty organizing, queer politics, race politics, anti-colonial resistance, diaspora, and the various human rights movements, such as women's rights, children's rights, disability rights, and trans rights, among others,"

which are all relevant to Canadian health policy and activism (Menzies et al., 2013, p. 3). Moreover, by challenging the biological model of mental illness, Mad studies research highlights experiences of resistance, oppression, marginalization, and psychiatric systemic violence from Mad activists and psychiatric survivors (Menzies et al., 2013). Overall, Mad studies and movements seek to liberate Mad people from the bounds of traditional psychiatry while shifting mental health ideologies and politics (Menzies et al., 2013). Adopting a Mad studies perspective when studying the opioid crisis allows me to better understand the lived experiences of people with mental health challenges and how they were viewed and treated in both society and medicine. Despite countless Mad movements and activism, some of the prejudice towards mental illness still persists today, which has an influence in Canadian mental health and drug policy.

Health Equity

According to PHAC (2022), health inequities are health inequalities that are unjust. Promoting health equity involves implementing policies that ensure all have a fair opportunity to access health care and social services in Canada (PHAC, 2022). This, in turn, reduces SDH disparities for systematically disadvantaged populations (PHAC, 2022). For example, it is known that Canadians living in Northern or remote regions have limited access to certain resources and services compared to those residing in the South (PHAC, 2022). Moreover, vulnerable populations like those experiencing homelessness, racism and gender inequities are more likely to experience health inequities (PHAC, 2022).

Health inequities (and the SDH that produce them) are rooted in the ethical principle of social justice (Raphael, 2019). Raphael argues that acknowledging this principle is critical for two reasons when assessing population health. First, social justice requires goods, services and resources to be distributed equitably (Raphael, 2019). Second, social justice demands transparency and democracy from the government, and empowerment from the population (Raphael, 2019). Together, political equality is achieved, causing a shift in policy making (Raphael, 2019). As a result, equitable healthcare is prioritized, human rights are respected, and health disparities decrease in the population (Raphael, 2019). Keeping the concept of health equity in mind is important for this research, as those struggling with addictions and mental health challenges may have inequitable access to the health care and social services they require, especially those in Northern Ontario.

Research Question

Given the evidence of how successful the harm reduction approach has been at addressing substance use, what can we learn about political barriers and the role of activism through a comparison of harm reduction policies and practices in British Columbia and Ontario?

History of the Opioid Crisis in British Columbia

The opioid crisis has been an ongoing public health issue in British Columbia for over two decades. Beginning in the 1990s, the rate of heroin overdoses grew exponentially in the Downtown East Side (DTES) neighborhood of Vancouver (Fafard, 2012). As a result, the Chief Coroner argued for the legalization and decriminalization of drugs in an effort to emphasize drug abuse as a public health threat rather than illegal crime (Fafard, 2012). Throughout the 1990s, this crisis continued to exacerbate as the injection drug epidemic progressed, and the rates of HIV infections began to rise (Fafard, 2012). By 1997, the Chief Medical Officer in Vancouver declared a public health emergency, and a report was released by the Provincial Health Officer of the Government of British Columbia urging the implementation of harm reduction practices to help alleviate this threat to public health (Fafard, 2012). As the opioid crisis continued to worsen, it was not only a concern in public health but also in the political realm (Fafard, 2012). Following the city of Vancouver's lead, municipal, Provincial and Federal governments increased funding for harm reduction practices in an effort to reduce injection drug-related mortality and morbidity (Fafard, 2012). The Federal government and Government of British Columbia added *harm reduction* as one of their *Four Pillars of Drug Strategy*, inspired by Switzerland's approach to mitigating drug use harms in the 1980s (Fafard, 2012).

In addition to these political efforts, community and grassroots organizations also made an effort to address the increased opioid-related deaths and incidence of HIV (Fafard, 2012). By raising public awareness, starting new initiatives, and pushing for

government action, harm reduction practices (like needle exchange) became more popular with the hopes of providing short term relief to the harmful effects of drug use (Fafard, 2012). Additionally, these community groups were lobbying for SIS to be implemented long-term (Fafard, 2012).

Implementation of INSITE

By 2003, the Government of Canada allowed the Vancouver Coastal Health Authority (VCHA) to be exempted from the Controlled Drugs and Substances Act, which granted permission for the development of INSITE—the first medically supervised safe injection facility in North America (Fafard, 2012). At the time, such a radical approach to addressing the crisis was the result of three factors, the first being the rise in HIV/AIDS and the severity of overdoses demonstrated the need for immediate action (Fafard, 2012). Second, policy advocates, political leaders and community groups lobbied for a new way of addressing the issue (Fafard, 2012). Specifically, local community groups like the Portland Hotel Society and the Vancouver Area Network of Drug Users (VANDU) advocated for change, along with Vancouver Mayors Philip Owen and Larry Campbell (Fafard, 2012). VCHA and the Government of British Columbia also demonstrated notable political leadership and advocacy (Fafard, 2012). The final factor contributing to the implementation of INSITE was a shift in public opinion towards drug use (Fafard, 2012). Albeit a long process, harm reduction advocates continued to protest and host media events with the hopes of influencing policy makers to support harm reduction philosophy and thus safe injection facilities (Fafard, 2012). Lobbying groups even went

as far as opening facilities without government approval to demonstrate the severity of the demand for help (Fafard, 2012). Some argue that evidence-based research was not the most important driving factor, but rather the pressure from a coalition of drug activist groups and their communities (more on this later) (Fafard, 2012). Overall, it took several years of multisectoral support to finally encourage the development of INSITE.

After several years of decision making, INSITE finally opened on East Hastings street in 2003 as a pilot project by the British Columbia Centre of Excellence for HIV/AIDS (Fafard, 2012). Although it was initially given a 3-year exemption, less than 18 months later, the new Conservative government was elected in Canada, and with a new political stance on crime and illegal drug use, the Federal Minister of Health granted INSITE's renewal only until December 31, 2007 (Fafard, 2012). Drug activists and community groups fought against closure threats from the Federal government, arguing that closing INSITE would result in a human rights violation for those who frequent the facility (Fafard, 2012). Rather than framing their argument around the benefits of SIS, advocates instead argued that SIS, like INSITE, promote social justice (Fafard, 2012). Specifically, they argued that INSITE is the only just and effective approach to supporting those who are experiencing mental health challenges like addiction in Vancouver (Fafard, 2012). Therefore, the closure of INSITE would inevitably shift the depiction of drug use back to a criminal one, erasing all the activism and progress that had been successful up until that point (Fafard, 2012). In turn, drug users would be deprived of their fundamental human rights under the Canadian Charter of Rights and Freedoms, which created grounds for a legal case (Fafard, 2012).

In September 2012, a legal case was brought to the Supreme Court of Canada where the Court decided to uphold the right of the Minister to enforce the *Controlled Drugs and Substances Act* (Fafard, 2012). This decision meant that federal jurisdiction over criminal law would overpower provincial jurisdiction over health (Fafard, 2012). However, in a more positive light, the Court also stated that the individual rights of drug users are protected by the *Canadian Charter of Rights and Freedoms*, which requires INSITE to be exempted from federal drug control legislation (Fafard, 2012). Overall, the Court's decision was considered a small victory, and a step in the right direction towards alleviating the opioid crisis through lifesaving safe injection facilities (Fafard, 2012)**.**

The Impact of Fentanyl

Despite this small victory, illicit drug-related overdoses continued to rise in British Columbia. As of April 2016, a public health emergency was declared by the British Columbia Provincial Health Officer due to the alarming rates of drug overdoses and deaths (Neilson et al., 2020). By November 2016, the *Joint Statement of Action to Address the Opioid Crisis* was released by the Federal government, addressing the collaboration of 30+ organizations, and highlighting the severity of the crisis nationwide (Neilson et al., 2020). Data in the statement indicates that the most opioid-related deaths in 2016 occurred in British Columbia, with rates of over 20 per 100,000 population—the highest rate nationwide (Canadian Centre on Substance Use and Addiction, 2016). Research from Baldwin et al. (2018) indicates that drug-related deaths involving fentanyl were still rapidly increasing in 2016. Through their research, they examined the

association between fentanyl-related overdoses and heroin overdoses, and found that although both were contributing to the opioid crisis, more accidental overdoses were a result of illicit fentanyl use (Baldwin et al., 2018). This may be a result of unintentional consumption, as many people who use drugs are unaware if their sample contains fentanyl (Baldwin et al., 2018). They suggest that the low production cost and easy concealment during transportation contribute to its popularity on the black market, further contributing to the crisis (Baldwin et al., 2018). Fentanyl-related overdoses continued to increase in 2017, with 706 deaths from January–July in British Columbia (Baldwin et al., 2018).

The Impact of COVID-19

On March 11, 2020, the WHO declared the viral COVID-19 disease outbreak a pandemic. In their (2021) study, Galarneau et al. conducted semi-structured qualitative interviews to better understand the experiences of people with opioid use disorder in British Columbia during the pandemic. Their findings showed that many faced challenges accessing harm reduction, medical and social services due to physical distancing measures and other public health measures that were in place (Galarneau et al., 2021). Accordingly, participants reported an increase in precarious behavior, such as trying new substances and purchasing more substances (Galarneau et al., 2021). They also consumed drugs alone more frequently, as overdose prevention facilities and SCS were inaccessible due to physical distancing, long wait times, or permanent closures (Galarneau et al., 2021). These findings are consistent with literature from Russell et al., (2021) as well. As

expected, the already high levels of opioid-related overdoses spiked, and there was a 116% increase in illicit drug-related mortalities from October 2019–October 2020 as indicated by the British Columbia Coroners Service (VANDU et al., 2021). Overall, the literature indicates that inaccessible harm reduction services during the COVID-19 pandemic prevented people who use drugs from consuming safely with medical supervision, leading to the elevated drug overdose and death rates in British Columbia.

In conclusion, this brief overview of the history of the opioid crisis in British Columbia outlines the province's ongoing war against drugs since the 1990s. The COVID-19 pandemic exacerbated the already alarming rates of opioid-related overdoses, increasing the demand for more accessible harm reduction services to support people who use drugs in British Columbia. In the following sections, I will discuss how evidence-based research and ongoing activism have been enablers of harm reduction practices like SIS. Special attention will be given to INSITE, North America's first safe injection facility, and VANDU, the most well-known drug activist group in Vancouver.

Enablers of Harm Reduction

Evidence-Based Research

As evidenced by the literature from Berrigan and Zucchelli (2022), a common barrier to implementing SIS was the concern for its economic burden on the healthcare system. Despite this social and political controversy, research from Pinkerton (2010) indicates otherwise, demonstrating that safe injection facilities actually decrease the burden and instead are highly cost-saving. More specifically, their economic analysis

revealed that INSITE yields $17.6 million in savings to the healthcare system as a result of their syringe exchange program (Pinkerton, 2010). INSITE reduces approximately 83 HIV infections per year—a 31% reduction in the expected incidence (Pinkerton, 2010). Therefore, reduced incidence and health care savings offsets the $3 million investment to operate INSITE, highlighting the economic benefits of an SIS and its programs (Pinkerton, 2010). These findings from Pinkerton (2010) are consistent with research from Andresen & Boyd (2010), who also argue that INSITE is an economically favorable and productive strategy for mitigating the injection drug epidemic in the DTES in Vancouver—"INSITE is a good value for the resources that it consumes" (Andresen & Boyd, 2010, p. 74).

In addition to being cost-effective, INSITE has also been shown to reduce drug-related overdoses and mortality in British Columbia (Jozaghi & Andresen, 2013; Marshall et al., 2011). Marshall et al., (2011) conducted a retrospective population-based analysis in Vancouver, and their findings indicate a 35% reduction in drug overdoses within 500 m of INSITE after its opening (Marshall et al., 2011). Moreover, in their (2013) study, Jozaghi and Andresen interviewed INSITE service users, and found that injection drug users in Vancouver prefer using at INSITE rather than in public due to the increased safety and reduced risk of overdose at the site. Overall, SIS are a safe and effective strategy to reduce the burden of drug overdoses on public health, especially in neighborhoods with alarming overdose rates (Marshall et al., 2011).

In conclusion, this brief review of evidence-based research has shown that INSITE (like other SIS) is economically favorable for the healthcare system, as it reduces

HIV incidence and drug-related overdose mortality. Previously, I outlined Fafard's (2012) research, which suggests that activism in British Columbia was the primary driving factor for policy change, as opposed to only evidence-based research. So, in this next section, I will discuss the history of VANDU, and how their ongoing efforts to support the rights of people who use drugs was beneficial in the past, and still continues to be today.

Activism

History & Structure of VANDU. The most well-known activism group in British Columbia is VANDU. Founded in 1998 and still operating today, VANDU has been providing support to drug users, their families and communities for over 20 years (VANDU, n.d.). "[They] are a voice for people who use drugs and an organization where the most oppressed and marginalized can have a voice, act as citizens and exercise real decision-making power" (VANDU, 2010, p.1). The group is composed of previous and present drug users who use peer-based education to support the lives of drug users, encouraging safer and healthier living (VANDU, n.d.). By including people who use drugs in the policymaking and design process, VANDU challenges the traditional hierarchical relationship involving a client and service provider, empowering drug users to be involved in the design and implementation of programs and services meant to support them (VANDU, n.d.). Ultimately, these practices support a *nothing about us without us* philosophy[3] (Jürgens, 2005).

[3] "Nothing about us without us" is a common motto used in the international disability movement and among communities of people who use drugs (Jürgens, 2005, pp. v-vi). This motto symbolizes that individuals should be involved in the development of policies that affect them, ultimately promoting an equal and just society (Jürgens, 2005).

In addition to promoting community empowerment, VANDU recognizes the complexity of drug addiction, and that it is often challenging to abstain from drug use completely (VANDU, n.d.). Also, not all people who use drugs use them the same—the spectrum varies from minimal use to severe abuse (VANDU, n.d.). Furthermore, VANDU acknowledges how substance abuse is often intertwined with experiences of social inequalities, like poverty, racism, traumas, and mental health difficulties, and structural violence, which increases vulnerability to drug-related harms (Jozaghi et al., 2018; VANDU, n.d.). Overall, their mission includes "ending the stigma, criminalization, and marginalization which are a consequence of the ill-conceived war on drugs" (VANDU, 2010, p. 1). Through this brief overview of VANDU's philosophies, it is clear that their harm reduction programs and policies support the idea that everyone has a right to health and wellbeing (VANDU, n.d.).

In their (2006) study, Kerr et al., outline the history of VANDU, its structure, and variety of programs through semi-structured interviews and a review of historical records. Historically, the DTES has been a popular neighbourhood for grassroots activism in Vancouver (Kerr et al., 2006). In 1997, drug users and activists throughout the DTES formed a collective to address the injection drug overdose crisis following the public health emergency announcement from the Chief Medical Officer (Kerr et al., 2006). The founders of VANDU were influenced by Liberation Theology—a grassroots revolutionary movement with Catholic theologians that arose in 1960s Latin America (Kerr et al., 2006). Their ideologies and principles focused on creating social justice through the development of a new society (Kerr et al., 2006). The founders of VANDU

held large group meetings in public spaces in the DTES, bringing Liberation Theology values into their discussion (Kerr et al., 2006). They believed that publicizing the pain and suffering of people who use drugs fostered an open spiritual movement, thus challenging traditional methods of addressing drug addiction at the time like psychiatry and the mental health care system (Kerr et al., 2006). During the meetings, group members asked questions like "'what are the issues facing drug users? and 'what would most help you now?'" (Kerr et al., 2006, p. 63). As time progressed, the meetings saw higher attendance rates, reaching upwards of 100 attendees within the first few months (Kerr et al., 2006). With the help of founding members and political support, the group was able to withstand other local groups who were resistant, and finally, the group was established as a non-profit society called the "Vancouver Area Network of Drug Users" (Kerr et al., 2006, p. 63). VANDU group members attended health and police board meetings, and open-mike events with the hopes that media coverage would help spread the word about the severity of the crisis (Kerr et al., 2006). The local needle exchange operator at the time had refused to provide VANDU with clean syringes, but thanks to the media, eventually, local politicians, health authorities, and nurses became aware of the situation, and began to provide syringes for VANDU instead (Kerr et al., 2006).

Upon reviewing historical documents and interviews, Kerr et al., noticed three themes in VANDU's guiding principles. First, VANDU rejects elitism and exclusivity by including current and former drug users in their program development, therefore promoting and practicing inclusivity in every aspect of their organization (Kerr et al., 2006). Next, organizational decisions are all made by service recipients (Kerr et al.,

2006). Finally, VANDU encourages mentorship within their organization, meaning that anyone interested in learning particular skills can learn from their experienced peers (Kerr et al., 2006).

Advocacy Work. VANDU's early drug user advocacy and political activism were based on the aforementioned Liberation Theology principles (Kerr et al., 2006). Their main goal was to demarginalize drug users in Vancouver by involving their voices in political discourse (Kerr et al., 2006). Some of their first activism work involved protesting against city council and their lack of recognition towards the severity of the drug crisis (Kerr et al., 2006). For example, when the city implemented a 90-day moratorium on new drug user services in Vancouver, VANDU protested by interrupting a city council meeting with a coffin to demonstrate their concern for the public health emergency (Kerr et al., 2006). In addition, they organized two events where local residents wrote the names of loved ones who died due to drug overdose on crosses in a park (Kerr et al., 2006). Moreover, because political barriers were delaying the development of INSITE, VANDU implemented a peer-run SIS in the interim as a protest against local law and political authorities (Kerr et al., 2006). Furthermore, they won intervener status during their support for a low-threshold contact centre in a Provincial Supreme Court case, which forced the opposing neighbourhood group to withdraw (Kerr et al., 2006). One policy maker acknowledged the impact of VANDU's activism, saying, "you always need loud, vociferous folks out there on the edge so the centre moves ... and you can't ignore those guys. They're vocal, they're very passionate, and they are trying to hang on to the agenda until something significant occurs" (Kerr et al., 2006, p. 64).

VANDU representatives are now common attendees at municipal, provincial and federal policy meetings, and have participated in the development of Canada's Task Group on Injection Drug Use and the national AIDS Strategy (Kerr et al., 2006).

In addition to grand scale activism, Kerr et al., also investigated the experiences of members directly, noting how VANDU's work impacts program recipients. For example, some expressed how challenging it is to advocate for oneself, especially addicts or populations with lower socioeconomic status who are usually treated horribly in the political agenda (Kerr et al., 2006). One participant emphasized the importance of VANDU's passion towards injection drug users (IDU), "they are seen as the voice of IDU, and that voice is being listened to because it is rational and passionate. If there was [no] VANDU, then how would the IDU community communicate? They would suffer a lot" (Kerr et al., 2006, p. 64). Moreover, several participants noted VANDU's impact in shifting public perceptions about drug use and users (Kerr et al., 2006). Historically, there was a lack of understanding about injection drug use and the real experiences of people who use them, but through their comprehensive and open education programs, VANDU has been a key educator for the public—"you want to know? Come on down and we'll show you" (Kerr et al., 2006, p. 64).

Education & Support Programs. Most of VANDU's education and support programs are geared towards improving social and health issues (Kerr et al., 2006). For example, they have support groups for people with hepatitis C and women with HIV (Kerr et al., 2006). The BC Association of People on Methadone was originally a VANDU group that has now become its own non-profit organization (Kerr et al., 2006).

The Housing Action Committee, another subgroup of VANDU, protests for more housing in Vancouver through radical activism in parks and government offices (Kerr et al., 2006). In addition, VANDU implemented an Alley Patrol programme to address the increased number of people who use injection drugs in alleyways and other public spaces (Kerr et al., 2006). Volunteers undergo CPR and first aid training, and work 4-hour shifts to provide harm reduction education, sterile syringes, and water, and also collect used syringes from the alleyways and low-income hotels (Kerr et al., 2006). As a result of its success, the British Columbia Centre for Disease Control collaborated with the Alley Patrol programme, which allowed for nurses to develop trusted and meaningful relationships with drug users who use on the streets (Kerr et al., 2006). A program recipient explained, "VANDU, to me, is our country's protection against HIV and other diseases. It's the fight that we need. That is VANDU to me" (Kerr et al., 2006, p. 66). Moreover, a common issue for people who use drugs in Vancouver was the lack of clean syringes available at night, so in September 2001, VANDU implemented an unsanctioned syringe exchange program that operated out of a tent for 9 months during night hours (Kerr et al., 2006). By May 2002, the Vancouver Police Department shut down the operation and funding was cut (Kerr et al., 2006). After a long period of negotiating, VANDU established two indoor needle exchanges—one in a health centre and the other a hotel (Kerr et al., 2006). VANDU service users were unhappy with the move though, as they had appreciated the accessibility of the outdoor tent and its low-barrier status (Kerr et al., 2006). Overall, VANDU is responsible for a number of harm reduction programs in the DTES which have been helping to reduce HIV incidence and overdose.

In addition to their investigation into the different types of programs VANDU offers, Kerr et al., also outlined some of the reasons program recipients felt supported by VANDU. First, some expressed their gratitude for the peer mentorship program, as they felt more comfortable talking about their experiences with drug use with someone else who has experienced similar struggles with addiction: "It means a lot to me that those guys know where I'm coming from" (Kerr et al., 2006, p. 66). More specifically, the empathetic aspect of the peer support meant the most to some: "[...] I'm not going to listen to somebody who isn't a drug user telling me that they know how I feel. I just liked the fact that they were drug users" (Kerr et al., 2006, p. 66). Next, some recipients expressed feeling acknowledged, appreciated and included when accessing VANDU's services (Kerr et al., 2006). For example, belonging to an organization like VANDU makes them feel good about themselves, the silver lining in a typically negative and stigmatized drug use discourse (Kerr et al., 2006). Furthermore, one member explained that VANDU provides a chance for drug users to feel responsible and competent, therefore fostering personal and professional growth during challenging times (Kerr et al., 2006). Specifically, because drug users themselves are so involved in all VANDU's processes—from policy design to front-line work—they feel more valued than if they were just program recipients (Kerr et al., 2006).

Other Activist Groups. VANDU is a multifaceted activism group, meaning that it does its own activism work, and it is also composed of sub-activist groups. Their website provides a brief description of these subgroups, which include: Eastside Illicit Drinkers for Education (EIDGE), Tuesday Group, BC Association of People on

Methadone (BCAPOM), and Western Aboriginal Harm Reduction Society (WAHRS) (VANDU, n.d.).

History of the Opioid Crisis in Ontario

In the previous section, I outlined the history of the opioid crisis in British Columbia and the ongoing grassroots activism from VANDU. In this next section, I will discuss the opioid crisis in the Ontario context, focusing on the history of SCS policy making beginning in 2016, along with the barriers that prevented (and are still preventing) the implementation of essential harm reduction services. Special attention will be drawn to equity issues in Northern Ontario, especially in my hometown of Sault Ste. Marie. The alarming rates of opioid addiction and overdose provide a rationale for making Sault Ste. Marie and the Algoma region areas of focus for this research (APH, 2023).

Differently from the 1990s in British Columbia, statistics suggest that the opioid crisis began much later in Ontario. According to Public Health Ontario (PHO), there was a minimal rise in opioid-related morbidity and mortality rates from 2003–2016, and then a large spike in 2017 (6.2 per 100,000 to 9.1 per 100,000) (PHO, 2023). Following the 2016 Federal election, the new Liberal government addressed these rising mortality rates by adopting a harm reduction approach in their drug policy through changes to the *Controlled Drugs and Substances Act* (Russell et al., 2020). This new policy, known as Bill C-37, resulted in a less burdensome application for new SCS and the renewal of existing ones (Government of Canada, 2016b; Russell et al., 2020). By streamlining the

application process, Bill C-37 ensured that SCS could be more easily constructed, thus recognizing their effectiveness at saving lives amidst a deadly epidemic (Russell et al., 2020). This was seen as an important step towards improving the lives of people who use drugs nationwide, however, activists and front-line workers were still struggling to obtain approval to build SCS from provincial health ministers, along with municipal governments (Russell et al., 2020).

In 2017, the rates of opioid-related overdoses were still on the rise and provincial barriers were still persistent (PHO, 2023; Russell et al., 2020). Acknowledging this public health crisis, the Federal government approved a class exemption for all provinces to fund temporary OPS; a more flexible, low-barrier and low-threshold option compared to SCS (Russell et al., 2020; Strike & Watson, 2019). The Minister of Health in each province has the authority to analyze the demand for a SCS in each community that submits an application, and it is up to their discretion to approve the class exemption (Government of Canada, 2018). In the past, OPS were traditionally run out of tents or easily modifiable structures as a form of short-term support by grassroots groups, volunteers and drug activists with the hopes of demonstrating the demand for a long-term SCS in their communities (Russell et al., 2020). This new exemption now ensured OPS would be funded by provincial governments, which was seen as another key step to reducing the burden of the opioid crisis in each respective province (Russell et al., 2020).

Despite the new legislative changes and support from the Federal government, not all provincial governments conformed and provided their own individual support to address the crisis (Russell et al., 2020). Support or opposition of OPS and SCS, and

accordingly, the implementation of healthcare services is entirely dependent on government authorities who are in control of health policy. Previously, I demonstrated that through their continued activism, British Columbia was mostly successful in advocating for the expansion of OPS and SCS province-wide, which has resulted in cost-savings to the healthcare system and a reduction in drug overdoses. Differently, in other provinces, like Ontario, the use of SCS and OPS as strategies to mitigate the crisis have been a controversial topic in both the political realm and common discourse.

In 2018, the new Ontario provincial election resulted in a shift from a Liberal government to a Conservative government (Russell et al., 2020). As such, a government that once supported harm reduction policy was now replaced by one that was "dead against" SCS (Russell et al., 2020, p. 2). Instead of further developing the existing SCS/OPS programs across the province, the Conservative government opted for a 'streamlined' and rebranded model—consumption services treatment (CTS) (Russell et al., 2020; Strike & Watson, 2019). This new policy meant that existing SCS/OPS were now mandated to connect individuals to another form of rehabilitation or treatment (Russell et al., 2020). In addition, SCS/OPS needed to re-apply for a federal exemption and provincial funding if they wished to remain open under the new government standards (Russell et al., 2020). Furthermore, the maximum number of CTS sites province-wide was capped at 21 arbitrarily—the current number that was operating in 2018—not including illegal or semi-legal facilities (Russell et al., 2020).

The Provincial government justified these policy changes by arguing that their decisions were based on multi-sectoral evidence from health care professionals,

SCS/OPS staff and members of various communities in a 2018 review (Russell et al., 2020). The Conservatives hoped that their new policy would prioritize other forms of treatment and rehabilitation (i.e. medical model of care) over harm reduction (i.e. social model of care), which shifts the drug use narrative back to the traditional model of eliminating substance use altogether instead of mitigating the harms associated with it (Russell et al., 2020). For example, in the review, the government states, "the sites are not sufficient as standalone entities disconnected from other services; sites should support individuals to seek addictions treatment as well as other health and social services" (Ontario Newsroom, 2018, n.p.). On the other hand, the lack of addictions treatment and mental healthcare services is also acknowledged in the review, so, how can individuals with mental health and addictions challenges be supported beyond harm reduction services if there are no adequate services available? Although other services are important, Russell et al. (2020) argue this approach fails to recognize the unique low-threshold and low-barrier nature of harm reduction services—elements that respect individual autonomy, and do not promote coercion of medicalized treatments for people who use drugs. These elements are among many of the reasons individuals seek harm reduction services as opposed to the medicalized health care system in Ontario (Russell et al., 2020). Furthermore, the Provincial government acknowledged the positive impact of SCS on communities with high drug overdose rates, stating that they "lower rates of public drug use and needle sharing, improve the health of those who use drugs and reduce

strain on the health care system, and are cost-effective," yet the maximum amount of facilities province-wide was capped at 21[4] (Ontario Newsroom, 2018, n.p.).

On March 29, 2018, the Provincial government approved only 15 CTS in mostly Southern Ontario jurisdictions (Toronto, Ottawa, London, Guelph, Hamilton, Kingston, St. Catherines), with the exception of one site in the Northwest (Thunder Bay). The hope was this new CTS model would increase the availability of mental health and addictions services province-wide, however, some of the existing SCS/OPS were not included in the approved 15[5] (Russell et al., 2020). In order to remain operational, the remaining sites were forced to arrange their own funding via fundraising, as the government had ceased providing monetary support (Russell et al., 2020). Overall, the 2018 review of the new CTS model illustrates that provincial policy making contradicted evidence, community needs, and Bill C-37, making the new model detrimental to the health and wellbeing of people who use drugs in Ontario.

Moving forward, the COVID-19 pandemic put a halt to the minimal harm reduction services that were operating in Ontario, leaving many people who use drugs without SCS/OPS. And, similar to British Columbia, the pandemic also exacerbated drug-related deaths in Ontario. By March 2020, the rate of opioid-related mortality increased 55.1% from 2019 (10.7 per 100,000 to 16.6 per 100,000), and continued to increase to 19.1 per 100,000 in 2021 (PHO, 2023). Research from Russell et al. (2021)

[4] It is difficult to suggest exactly how many sites would have been ideal as there are many determining factors, however, given the alarming overdose statistics (especially in Northern regions), I expected there to be more than 21 sites province-wide.

[5] The Government of Ontario did not provide a detailed explanation as to why or how these 15 sites were selected, but rather a general statement saying they "approved 15 sites in areas with the greatest need" (Ontario Newsroom, 2019, n.p.).

highlights the impact of COVID-19 on the lives of people who use drugs. Their findings showed that SCS/OPS had limited hours or were closed altogether, and there was an overall lack of harm reduction resources like clean syringes (Russell et al., 2021). As such, many people resorted to using drugs more precariously (Russell et al., 2021). In addition, self-help groups and addictions counselling services operated online instead of in-person, generating equity and accessibility concerns for people who do not have the required technology (Russell et al., 2021). Finally, those who sought treatment programs during the pandemic were put on lengthy waitlists, or were turned away indefinitely because of service cancellations (Russell et al., 2021).

Overall, this brief history review highlighted the problematic role of the Ontario Provincial government amidst the opioid epidemic. Despite efforts from the Federal government to advance the implementation of SCS nationwide, the Conservative Provincial government took an already successful SCS model, and rebranded it as a more burdensome and limited CTS model. Therefore, when the COVID-19 pandemic began in March 2020, it is no surprise that the already flawed system contributed to an increase in opioid-related deaths province-wide.

Enablers of Harm Reduction

Activism

The most notable drug activism in Ontario comes from the Toronto Harm Reduction Alliance (THRA), a coalition of drug users, researchers, harm reduction workers, students, and allies (Foreman-Mackey et al., 2019; THRA, 2021). Known as the

"beating heart and front-runners for harm reduction and policy change in the GTA," this group promotes harm reduction philosophy as a way to reduce drug use stigma and protect the lives of drug users in Southern Ontario (THRA, 2021, n.p.). THRA advocates for drug user rights by educating the community and fighting against discrimination and social inequalities (THRA, 2021). They seek to empower drug users to have a voice through their belief that "everyone has value and is valued" (THRA, 2021, n.p.).

The THRA was originally named the Safer Crack Use Coalition (SCUC), which advocated for clean crack-smoking supplies and resources in Toronto (THRA, 2021). Eventually, a city-funded organization began providing these resources, and the SCUC rebranded as the THRA in 2012, focussing on general harm reduction advocacy instead of just crack use advocacy (THRA, 2021). Throughout the last decade, THRA has been involved with various initiatives and drug user movements. In April 2014, they introduced the Toronto Harm Reduction Workers' Union—the first of its kind worldwide (THRA, 2021). In 2015, they collaborated with the Canadian AIDS Treatment Information Exchange to develop and implement a Peer Worker Forum which addressed new harm reduction initiatives and frontline worker training (THRA, 2021). In addition to advocacy work, the THRA also organized the National Day of Action on Overdose Deaths (February 20) and the International Day of Overdose Awareness (August 31) (THRA, 2021).

The THRA activists later formed a subgroup, known as the Toronto Overdose Prevention Society (TOPS) in 2017 (THRA, 2021). Together, they opened the first unsanctioned OPS in August 2017 in Moss Park to combat the rising levels of drug

overdose in the nearby South Riverdale neighbourhood (Foreman-Mackey et al., 2019; Lavoie, 2017). This OPS was inspired by the VANDU-led OPS and activism work in British Columbia, as evidence-based research indicated that these peer-led, unsanctioned services prevent drug overdoses, and provide support to vulnerable populations of people who use drugs (Foreman-Mackey et al., 2019). The Moss Park site operated without any government funding, depending on fundraising and donations for monetary support (Foreman-Mackey et al., 2019). Programs and services were primarily designed and implemented by TOPS members (especially those with lived experiences of drug use), along with the help of harm reduction and health care workers (Foreman-Mackey et al., 2019). In the beginning months, there were three tents: smoking, injections and supplies that operated daily from 4pm–10pm (Foreman-Mackey et al., 2019).

On August 10, 2017, harm reduction workers brought their concerns about the exacerbating opioid epidemic to Toronto Mayor John Tory (Lavoie, 2017). Zoe Dodd, an attendee at the meeting and the hepatitis C co-ordinator at the South Riverdale Community Health Centre, indicated her frustration with Toronto's lack of attention to the crisis, explaining that "[overdose prevention sites are] a vital and important service" (Lavoie, 2017, n.p.). Similarly, harm reduction and drug policy worker Nick Boyce addressed the need for the government to expedite their support: "Something should have been done yesterday. We've been calling on this for a long time [...] Governments may have made commitments, but in reality (money) isn't flowing as quickly as it should" (Lavoie, 2017, n.p.). In the interim, SIS provide a means of raising public awareness

about the severity of the opioid crisis, but more importantly, provide a safe community for people who use drugs in Toronto (Lavoie, 2017).

In addition to official advocacy groups like THRA and TOPS, Toronto has many unofficial groups of drug user advocates and allies who march and protest for drug user rights. In December 2017, protesters marched to City Hall from the Moss Park OPS and organized a "die-in," where they all collapsed in the rotunda, listing the names of friends and family members who had recently died due to drug overdose (Mathieu, 2017, n.p.). They urged Mayor Tory to support the implementation of more SIS, the decriminalization of drugs, and the opening of an emergency shelter for people experiencing homelessness (Mathieu, 2017). Additionally, they called upon the Mayor to limit police involvement at overdose crisis scenes (Mathieu, 2017). Moving forward, in 2018, the rates of opioid-related deaths were still on the rise (Reddekopp, 2018). Because the new Conservative government was conducting their evidence-based review that year, the development of the OPS sites in Thunder Bay, St. Catharines and Toronto had all been delayed (Reddekopp, 2018). Protestors challenged the Provincial and Federal government for their lack of attention to the crisis by marching downtown Toronto outside a federal symposium about the opioid crisis, and sending letters to Premier Doug Ford and Health Minister Christine Elliot (Reddekopp, 2018). One of the protestor's signs said "injustice is fatal," and Akia Munga, a drug user and harm reduction worker commented, "no one can access these services when people are dead," highlighting the urgency of the situation (Reddekopp, 2018, n.p.). Overall, the literature has noted THRA and TOPS are important drug activist groups in Southern Ontario. These groups have been advocating for drug

user rights and harm reduction policy for more than a decade, demonstrating their commitment to making a positive change in the lives of drug users and their communities.

Evidence-based Research

Drug policy is not only driven by activism from THRA and TOPS, but also by evidence-based research about harm reduction and SCS/OPS. A (2019) qualitative study conducted by Foreman-Mackey et al. examined the experiences of people who use drugs at the Moss Park OPS. Their findings showed that of the 139 overdoses that occurred at the site during their 4-month study period, 100% of them were reversed (53 with naloxone and 86 with oxygen and stimulation) (Foreman-Mackey et al., 2019). In addition to preventing drug overdoses, the site also provides a safe and welcoming environment for marginalized populations, reducing public consumption and protecting them from violence on the streets (Foreman-Mackey et al., 2019). Study participants indicated the Moss Park OPS is an inclusive community, free from stigma and discrimination—a "safe haven [...] a godsend [...] our sanctuary" (Foreman-Mackey et al., 2019, pp. 136–137). They reported that staff, volunteers and health care providers at the sights were welcoming, and offered generous amounts of care and time, making site users feel supported. One participant describes the staff as individuals who "love us until we love ourselves" (Foreman-Mackey et al., 2019, p. 137). Furthermore, the Moss Park OPS staff connects service users to treatment and detoxification services, and provides food, nursing care, and clothing (Foreman-Mackey et al., 2019). In addition to research

from Foreman-Mackey et al., CBC News also interviewed Moss Park OPS users to document their experiences at the site. One participant, Dave Gordon, frequents the site to use his drugs safely, but also to give back to the community with harm reduction safety kits (Sheldon, 2018). Akosua Gyan-Mante expressed her gratitude for the overdose prevention staff, saying "[The site] is giving me a fighting chance. It gave me life. It's giving me another day, another week, another month of being ok" (Sheldon, 2018, n.p.).

Furthermore, the findings in these two articles are in congruence with literature from Oudshoorn et al., (2021), who conducted research on another OPS in Ontario. Their study participants also expressed feelings of physical and emotional safety at the site, and appreciated the stigma-free space to use drugs and speak about their addictions (Oudshoorn et al., 2021). Many of the OPS users shared their experiences with social inequities like homelessness, trauma, mental health challenges, violence, marginalization, oppression, and discrimination, as well as intersecting identities like race, (dis)ability, sex, and gender—highlighting the complexity of their substance abuse (Oudshoorn et al., 2021). OPS staff helped facilitate connections to health care and social services like food, income and housing support (Oudshoorn et al., 2021). Moreover, participants formed meaningful relationships with the kind and compassionate staff, making them feel valued (Oudshoorn et al., 2021). As such, participants began using drugs less precariously and making healthier lifestyle choices simply because they knew someone cared about them and their wellbeing (Oudshoorn et al., 2021). Overall, it is evident that the Moss Park OPS, like other OPS in Ontario, is far from just an OPS; it is also a safe and inclusive community that supports the multifaceted needs of vulnerable populations.

Barriers for Small & Northern Communities

There are many complex barriers that are preventing Ontario from implementing harm reduction services like SCS/OPS. Small communities, especially those in Northern Ontario, are experiencing their own unique set of barriers compared to Southern regions. Russell et al. examine these barriers in their research, bringing light to the equity concerns faced by smaller communities.

Small Communities

Data has indicated that a large city population does not necessarily correlate with a higher rate of opioid-related deaths and hospitalizations, as many smaller communities in Ontario have been reporting rates higher than the provincial average. For example, the rate of opioid-related hospitalizations in communities with populations of 50,000–99,000 was higher than in larger populations (Russell et al., 2020). For example, Brantford (pop'n: 102,000) had a rate of 52.8 per 100,000, compared Toronto's (pop'n: 2.93 million) rate of 7.9 per 100,000 and Ottawa's (pop'n: 994,837) rate of 10.3 per 100,00, and finally the provincial (pop'n 14.57 million) rate of 14.8 per 100,000 (Russell et al., 2020). The Mayor of Brantford and municipal stakeholders have been advocating for CTS, however, provincial administrative requirements make it almost impossible to see its implementation through (Russell et al., 2020). Importantly, smaller communities in Ontario have recognized that there is an ongoing competition to obtain government approval and funding for a CTS program, so, despite the high demand for harm reduction

services, they may not win against larger cities like Toronto and Ottawa (Russell et al., 2020).

Aside from having to compete against metropolitan cities for provincial funding, smaller communities also face political and geographical barriers. First, drug use is a common controversy in the political realm, differing between provinces, regions, and communities (Russell et al., 2020). For example, rural and smaller communities in Ontario tend to be more conservative with their political ideologies, making it challenging to adopt a liberal value such as harm reduction (Russell et al., 2020). More specifically, health, social and drug policy discourse is dependent on the moral values of the community, which is why there is usually a notable divide between larger, urban cities and smaller, rural communities (Russell et al., 2020). In this sense, geography and politics intersect to create unique barriers to implementing SCS in smaller communities (Russell et al., 2020). Similar to Sharp et al., (2020) Russell et al., also acknowledge the NIMBY phenomenon where liberal communities support a hypothetical SCS, but oppose the actual implementation of them in their neighborhoods (Russell et al., 2020). Finally, community members who are opposed to CTS development in smaller communities may have the political power to prevent its development altogether, as the new CTS model requires continuous support from the public (Russell et al., 2020).

Small & Northern Communities

Small communities in Northern Ontario have a different set of unique barriers compared to small cities in Southern Ontario. Russell et al., (2019) conducted an in-depth

study about the barriers experienced by youth who use drugs in Northern Ontario. Interviews were conducted in 11 small, northern communities: Sault Ste. Marie, North Bay, Sudbury, Timmins, Smooth Rock Falls, Kapuskasing, Kenora, Fort Frances, Dryden, Sioux Lookout, and Thunder Bay (Russell et al., 2019). Their findings can be broken down into two themes: (1) treatment or service barriers and (2) treatment or service needs.

Treatment or Service Barriers. Personal, social, structural, and physical barriers make it challenging for youth to access the addictions services they need. First, many participants indicated there was an overall lack of information available about the addictions and mental health services in their communities (Russell et al., 2019). And those services were challenging to access and difficult to navigate. Second, many youth felt there was a lack of confidentiality in their small communities, and they feared others would find out about the treatments they were accessing (Russell et al., 2019). As such, they also feared being judged and stigmatized by family members, community members and friends (Russell et al., 2019). Notably, some participants indicated that systemic racism, discrimination and stigmatization were all deterrents to accessing health care services in their communities (Russell et al., 2019). Third, structural barriers like lengthy waitlists made it challenging for youth to seek help immediately, expressing that their "desire to get help was often fleeting and time-sensitive" (Russell et al., 2019, p. 8). Additionally, there are strict time limits for many treatment programs (e.g. rehabilitation and detoxification), and clients were rarely forwarded to other services they may require (Russell et al., 2019). The fourth barrier to seeking treatment was the overwhelming

administrative requirements, which is especially challenging for youth without proper government ID, and secure housing and income (Russell et al., 2019). Finally, physical barriers, such as lack of transportation and geographical isolation were common among the study participants (Russell et al., 2019). Specifically, Indigenous youth living on First Nations reserves found it particularly challenging to access services, as they would have to travel to nearby communities due to a lack of services on the reserve (Russell et al., 2019).

Treatment or Service Needs. In addition to discussing the deterrents of accessing addictions treatments, the youth also provided information about their service wants and needs. First, the youth expressed the need for harm reduction programs, such as a SIS with drug checking services (Russell et al., 2019). Second, low-threshold programs like a youth-specific drop-in centre were requested (Russell et al., 2019). The youth felt they would benefit from programs that do not coerce drug users into a specific form of treatment, but instead are more open and flexible (Russell et al., 2019). They also requested more 24-hour services, as the services that are available in their communities have limited operating hours (Russell et al., 2019). A centralized hub or walk-in centre would be beneficial, as it would house many different organizations and services in one location, making it easily accessible for everyone (Russell et al., 2019). Finally, the youth want peer-run counselling programs, as they felt that they would be more open to discussing addictions with someone who can empathize with their drug use experiences (Russell et al., 2019).

Sault Ste. Marie

Data from APH and PHO have indicated that the Algoma region is experiencing some of the highest rates of opioid-related overdoses and deaths province-wide, yet there has been little government action to address the severity of the issue (APH, 2023; PHO, 2023). In this next section, I will address the severity of the opioid crisis in Algoma and Sault Ste. Marie specifically, highlighting the demand for help from people who use drugs, community members, and local politicians.

According to PHO, opioid-related morbidity and mortality rates have been elevated in the Algoma region since 2016, with a large spike from 2019–2020 (14.9 per 100,000 to 45.6 per 100,000), likely due to the COVID-19 pandemic (PHO, 2023). Data from APH shows that the rate of opioid-related ED visits, hospitalizations and deaths in Algoma are all higher than the provincial rate (APH, 2023). For example, figure 1 shows that in 2017, Algoma experienced a rate of approximately 150 per 100,000 ED visits, compared to the rate in Ontario which was about ⅓ of Algoma's (APH, 2023). In 2021, the rate of ED visits peaked at an alltime high of about 200 per 100,000—two-fold the provincial rate (APH, 2023). In addition to the alarming levels of ED visits, opioid-related hospitalizations have been at a steady rate of about 10 per 100,000 for the province, but have been continuously fluctuating in Algoma, peaking at about 45 per 100,000 in 2017 (figure 2) (APH, 2023). APH warns that these data may be an underestimation of the actual number of opioid-related ED visits and hospitalizations, as not everyone who experiences opioid-related harms seeks official medical care and/or has an OHIP card (APH, 2023). Finally, the rate of opioid-related deaths has also been

consistently higher in Algoma for almost two decades, peaking at about 50 per 100,000 in 2021—more than two-fold the rate in Ontario (figure 3) (APH, 2023).

In a news article titled, *Sault still Among Deadliest Cities for Opioids: Chief Coroner*, Armstrong (2023) outlines the severity of the 2022 statistics from the Office of the Chief Coroner. The Algoma region saw the highest rate province-wide of opioid-related deaths in the last quarter of 2022 (14.1 per 100,000) (Armstrong, 2023a). Of the total 55 deaths, 44 occurred in Sault Ste. Marie, and the rest in other jurisdictions in Algoma (three deaths in Garden River First Nation, and two deaths each in Blind River and Elliot Lake) (Armstrong, 2023a). This data indicates that opioid toxicity deaths were highest in the city of Sault Ste. Marie in the last quarter of 2022, making it one of the worst cities affected by opioid harm province-wide (Armstrong, 2023a). The overall rate of opioid-related deaths in Sault Ste. Marie was 61.1 per 100,000 for the 2022 year (Armstrong, 2023a). Similar to British Columbia, most drug overdoses are caused by fentanyl and its analogues, and in 2022, 84% of opioid-related deaths can be attributed to fentanyl, and 7.6% to carfentanil (Armstrong, 2023a). Dr. David Juurlink of the Sunnybrook Health Sciences Centre describes the severity of the fentanyl crisis as “an epidemic within an epidemic” (Ubelacker, 2017, n.p.) .

Despite the clear demand for SCS/OPS in Sault Ste. Marie, the city has struggled to gain approval for its implementation by the Provincial government. The Canadian Mental Health Association (CMHA) and APH offices provide sterile drug paraphernalia, however, people who use drugs are prohibited from using them at these locations. As a result, many have resorted to using drugs in public spaces, which increases risky

behaviour and accordingly, the risk of accidental overdose. The opioid epidemic is a multifaceted issue in Sault Ste. Marie, as many people who use drugs are experiencing homelessness and mental health challenges, but have limited access to primary health care services. Unfortunately, addictions and drug use discourse in the community is riddled with stigma, as Annette Katajamaki (CEO of CMHA Algoma) explains, "It was all about 'why don't these people just stop using? What are we going to do with them?' as opposed to 'how have we failed as a community in helping folks get better or taking steps toward recovery?"' (Armstrong, 2022, n.p.). To combat these problems, especially during the COVID-19 pandemic, Katajamaki developed the Community Wellness Bus as a pilot project in collaboration with Algoma Family Services, Sault Area Hospital, the Superior Family Health Team and Social Services Sault Ste. Marie (Armstrong, 2022). Harm reduction outreach nurses transformed an ambulance into a "vehicle of hope" to provide nursing care, harm reduction services and supplies to Sault Ste. Marie's drug user population (Armstrong, 2022, n.p.). An important feature of the wellness bus is its mobility, which allows its services to be accessible to everyone around the community (Armstrong, 2022). It frequents the Soup Kitchen Community Centre, the Salvation Army, Pauline's Place (non-profit shelter) and St. Vincent Place (food bank) (Armstrong, 2022). Wellness bus staff typically provide take-away bags with snacks, harm reduction supplies like clean syringes, and toiletries (Armstrong, 2022). Harm reduction outreach nurse Erin McCaig notes the meaningful rapport and trust that drug users have formed with the wellness bus nurses and peer support workers, explaining that many vulnerable populations in Sault Ste. Marie have had poor experiences with mainstream health care

providers due to stigma and discrimination (Armstrong, 2022). Most importantly, the peer support workers have lived experience with addiction, which creates a sense of empathy between them and the wellness bus users (Armstrong, 2022). Katajamaki expressed her hope to see the Community Wellness Bus expand to other cities in Algoma, but it cannot do so without reliable government funding: “I want it to be a vehicle of hope [...] we all have to feel wanted and a part of [the] community” (Armstrong, 2022, n.p.).

In addition to community support from the Community Wellness Bus, political support can be mainly attributed to Sault Ste. Marie’s Mayor, Matthew Shoemaker, who has been an active advocate for harm reduction services (Armstrong, 2023b). By acknowledging the worsening opioid crisis in the city, he brings light to the health equity issues that are common in Northern communities, emphasizing, “It seems the further away you get from the Ministry of Health’s head offices in Toronto, the worse your statistics are. It seems obvious to me the sort of out-of-sight, out-of-mind mentality of Queen’s Park is continuing to play itself out in the healthcare field and across the north” (Armstrong, 2023b, n.p.). The disparity in harm reduction services (like SCS/OPS) in Sault Ste. Marie compared to Southern jurisdictions can be directly attributed to the government’s lack of funding and attention to the severity of the situation (Armstrong, 2023b). Currently, Mayor Shoemaker is collaborating with Ross Romano, Sault Ste. Marie’s member of Provincial Parliament to address these equity issues (Armstrong, 2023b). He hopes Romano can advocate for a re-allocation of provincial funding, which would help Sault Ste. Marie implement the services it urgently requires like a SCS, and the return of the Disorders Day Treatment Program (Armstrong, 2023b).

Further political support has also come from Sault Ste. Marie's CAO, Malcolm White, who is also supportive of SIS (Armstrong, 2023b). Typically, healthcare services are delivered by the Provincial government, but a difficult and lengthy bureaucracy makes it challenging to receive funding from the Provincial government (as evidenced by the aforementioned research) (Armstrong, 2023b). Accordingly, some Northern communities like Timmins and Sudbury have taken it upon themselves to open SCS with municipal funding (Armstrong, 2023b). As of May 2023, there are 24 SCS in Ontario—and not a single one in the Algoma region—the third worst region for opioid-related deaths (Armstrong, 2023b). Like Mayor Shoemaker, White also attributes the elevated death rates in Sault Ste. Marie to the lack of addictions and harm reduction services (Armstrong, 2023b). He has been communicating with health authorities in Sudbury, Timmins and Thunder Bay regions to gain a better understanding of their harm reduction strategies, with the hopes of developing similar strategies in collaboration with local health care and social agencies (Armstrong, 2023b).

Conclusion

The purpose of this research was to investigate the barriers and enablers of harm reduction as an approach to mitigating the opioid crisis in British Columbia and Ontario. Specifically, how do politics and drug activism influence harm reduction policy and practice in these provinces?

First, I reviewed the history of the opioid crisis in British Columbia. Following an increase in drug-related overdose mortalities, drug activists insisted on the

implementation of harm reduction services. Through a long process of protesting from VANDU, INSITE opened as North America's first SIS in 2003. This research demonstrated that a majority of policy reform and harm reduction programming is a result of VANDU's continued fight in the war against drugs, and their passion to support the human rights of drug users.

Furthermore, I examined the opioid crisis in the Ontario context, identifying the barriers that are preventing harm reduction services from being implemented in Northern Ontario. Following a rise in opioid-related mortality rates, the new Liberal Federal government released Bill C-37, which resulted in a less burdensome application for provinces to develop SCS. Instead of implementing SCS province-wide, Ontario opted for the CTS model. Similar to British Columbia, Ontario also experienced assertive activism, primarily from the THRA. Inspired by VANDU's OPS work in British Columbia, TOPS, a branch of THRA, opened the first unsanctioned OPS in Moss Park in 2017. The current literature indicates that Ontario is facing many barriers to implementing more harm reduction services, however, there is a unique set of barriers exclusive to Northern Ontario. Despite having higher rates of opioid overdose, Northern communities are often neglected when the Provincial government allocates funding for mental health care and addictions services. Finally, Sault Ste. Marie is experiencing some of the worst rates of opioid-related deaths province-wide, and yet there has been little action to address this issue. Mayor Shoemaker has indicated his frustration with the Ford government and their lack of attention to Northern communities—out-of-sight, out-of-mind—emphasizing the neglect faced by Sault Ste. Marie.

Throughout my analysis of the opioid crisis in British Columbia and Ontario, I used SDH, political economy, Mad studies and health equity as lenses to guide my research. In this next section, I will review the relevance of using these frameworks to analyze the opioid crisis in Canada. Then, I will conclude by providing suggestions for future research, policy, and practice.

Social Determinants of Health

If we examine the *bigger picture*, the opioid crisis extends beyond just an addiction problem; it is also linked to the homelessness crisis in Canada (like I outlined briefly above). Hence why it is important to consider the SDH (i.e. housing and access to health care resources) when analyzing the opioid crisis. The SDH framework allows us to appreciate the complexity of the opioid crisis. It is not a unidimensional issue—but rather a multifaceted health crisis that requires improvement in many other social and structural issues in order to see improvement. For example, safe and secure housing acts as a determinant of physical and mental health, however, over 235,000 Canadians experience homelessness each year (PHAC, 2021). Data from PHAC highlights the correlation between substance-related poisonings, mental health challenges, and homelessness, stating that people experiencing homelessness show higher rates of substance use, substance-related harms, and mental health difficulties compared to those with secure housing (PHAC, 2021). So, the COVID-19 pandemic not only exacerbated the opioid crisis, but also the homelessness and mental health crisis in Canada. Acknowledging the

relationship between these three factors provides a chance to better understand the role that social determinants (like secure housing) play in the ongoing opioid crisis.

At the Federal level, CIHI's national hospitalization data revealed that between April 2019 and March 2020, there were 10,659 substance-related hospitalizations, 6% being people experiencing homelessness (PHAC, 2021). 71% of these 6% hospital admissions were males, which may indicate higher rates of substance use and homelessness in males than females (PHAC, 2021). Most people experiencing homelessness and substance-related poisonings were ages 30–39 (33%), and ages 20–29 (23%), suggesting homelessness and opioid-related harms may be experienced more by younger Canadians (PHAC, 2021). Opioids were the most common substance reported in 61% of hospitalizations for patients experiencing homelessness, compared to 40% of those with secure housing (figure 4) (PHAC, 2021). 34% of opioid poisonings involved fentanyl among those who were homeless at the time of hospitalization (PHAC, 2021). Finally, more people experiencing homelessness reported mental health conditions (61%) compared to those with secure housing (52%) (PHAC, 2021).

In addition to considering the homelessness and opioid crises at the national level, it is also important to consider these issues at the regional and municipal levels. In her article, Lamothe (2023) discusses Northern Ontario's *hidden* homelessness crisis, focusing on the Algoma district. She argues that attention is often drawn to the homelessness and opioid crises in Southern Ontario, leaving the North hidden in the shadows (Lamothe, 2023). Since the onset of the COVID-19 pandemic, the rates of homelessness doubled in the North compared to the South (Lamothe, 2023). Specifically,

Sault Ste. Marie, Kenora, Nipissing and Cochrane had higher populations of homeless individuals per capita compared to London, Hamilton, Toronto or Ottawa (Lamothe, 2023). Lamothe explains that the homelessness and opioid crises were already severe pre-pandemic in the North, likely due to the rising cost of living, lack of health care services, limited income from social services like Ontario works and Ontario Disability Support Program, and inadequate living conditions (Lamothe, 2023). The pandemic exacerbated these issues with the closure of essential services and increased social distancing measures (Lamothe, 2023). As a result, many people experiencing homelessness in Northern communities set up tent encampments in public spaces, shedding light on the need for secure and affordable housing, along with support for addictions, cultural trauma and mental health challenges (Lamothe, 2023). Lamothe sums up the demand for help by saying, “make no mistake, people are dying” (Lamothe, 2023, n.p.).

Village Media conducted interviews with several social services managers across the North, including Sudbury, North Bay, Sault Ste. Marie, Timmins and Thunder Bay districts (Lamothe, 2023). Mike Nadeau, CEO of the District of Sault Ste Marie’s Social Services Administration Board, explained that in Sault Ste. Marie, 12–16% of the population are Indigenous Peoples, however, they make up 65% of the homeless population (Lamothe, 2023). This high percentage may be a result of inadequate housing and social services in First Nations reserves, which forces many Indigenous Peoples to migrate elsewhere (Lamothe, 2023). As a result, many experience homelessness and addiction challenges due to the lack of social and financial government support

(Lamothe, 2023). Moreover, Brian Marks, CAO of Cochrane's District Social Services Administration Board, explains that the homelessness crisis is more than just a need for more secure housing, but rather a need for more mental health and addictions service: "It's an addictions crisis with no end in sight. It's the lack of mental health and addiction support that are keeping people homeless [...] And without those supports, people will fail." (Lamothe, 2023, n.p.). Similarly, another social services manager explained, "[...] This isn't so much a housing crisis as it is a health-care crisis. Homelessness is the symptom, not the sickness. The lack of mental health and addictions support is the sickness" (Lamothe, 2023, n.p.). There is currently a lack of government funding to support the consequences of the pandemic, as current funding models are still based on pre-pandemic spending (Lamothe, 2023). Policy reform is therefore needed to adapt the models to the present-day crises and needs of people with mental health challenges who are also experiencing homelessness.

The Canadian Centre on Substance Use and Addiction estimates that 21% of Canada's population will experience addiction challenges during their life (Lamothe, 2023). And, individuals with mental illnesses are two times more likely to develop a substance use disorder (Lamothe, 2023). Unfortunately, current mental health services in Ontario are expensive and often involve lengthy waitlists (Lamothe, 2023). These services also differ between regions in Ontario, with more in the South compared to the North (Lamothe, 2023). So, people who are seeking treatment are often required to travel to different regions, emphasizing systemic issues which prevent people with addictions from receiving the treatment and support they need (Lamothe, 2023).

Research has clearly demonstrated that Northern Ontario is often neglected when health care funding is distributed by the Provincial government (Lamothe, 2023). 11–15% of Ontario's disease burden (financial cost of health problems) is due to mental illness and substance use disorders, yet, only 7% of health care funding is allocated to mental health care (Lamothe, 2023). Nadeau attributes the homelessness issue in Sault Ste. Marie to the lack of government funding and resources for community housing (Lamothe, 2023). He calls on the Provincial government to allocate more funding towards mental health care and services, along with a special sector dedicated to addictions care (Lamothe, 2023).

Albeit only a brief overview of how the homelessness crisis co-exists with the opioid crisis, this research highlights the severity of both crises in Canada (and Ontario specifically), and reinforces the importance of *looking at the big picture* when analyzing the opioid crisis. Far from an independent threat to public health, the opioid crisis is linked to other systemic and structural determinants of health, like a lack of secure housing and mental health care. In order to ameliorate both of these crises, it is important for policy makers to consider their coexistence when designing and implementing new mental health services, as people experiencing homelessness may have a different set of service needs than those with secure housing. It is worth noting that the data published by CIHI and the Government of Canada likely underestimates the number of people experiencing homelessness and mental health difficulties, as data was only recorded upon hospital admission and does not include those who did not seek hospital care. Overall, using the SDH as a framework encourages us to consider systemic issues that are

contributing to the opioid crisis. Further research is needed to examine homelessness and drug addiction in marginalized populations like racialized populations, Indigenous Peoples and LGTBQ+ people nationwide. In turn, we may have a better understanding of the complex lives of different demographics experiencing homelessness and addiction, which allows us to design and implement more harm reduction services tailored specifically to their needs.

Health Equity

In the previous section, I outlined how housing, an SDH, has been an integral factor in the exacerbation of the opioid crisis in Canada. In addition to the SDH lens, a health equity lens also brings value to my research, as it helps to highlight the inequities that act as systemic barriers for people with addictions residing in Northern Ontario. Specifically, my section 3 findings demonstrated that there is an overall lack of essential harm reduction services and resources for people with addictions and mental health challenges. And, the services that exist are often inaccessible or inadequate to meet the needs of Northern Ontarians. While Southern Ontario saw the development of several SISs in recent years, Northern regions were still fighting to secure long-term government funding for them. These issues become equity issues when we examine the opioid crisis in Ontario by region: provincial funding is invested into developing harm reduction services in Southern Ontario on account of its larger population, however, Northern Ontario, albeit smaller in size, has a substantially higher rate of opioid-related fatalities. So, even though statistics indicate that the North has a higher demand, the South receives

a majority of government support. This inequitable distribution of funding and resources neglects the principles of social justice and health equity, thus promoting the continuation of inequitable health disparities in the Northern region. Without a fair opportunity to access essential healthcare resources, Northern Ontarians will continue to be systematically disadvantaged, ultimately leading to worse outcomes compared to those residing in Southern Ontario.

Political Economy

Moving forward, a political economy lens also proved to be beneficial when examining the opioid crisis in Canada. In section 1, I outlined Raphael's (2011) and Wiktorowicz et al's., (2020) research on the importance of the welfare state at controlling policy making and accordingly, the distribution of mental health services across the province. My findings revealed that the welfare state impacted how each province reacted to the worsening opioid crisis, and accordingly, which steps were taken to alleviate the issue. British Columbia's Liberal government appeared to be more attentive to the crisis than Ontario's Conservative government. Moreover, my research highlighted the poor distribution of mental health care funding in Ontario, as the Southern regions received a majority of the resources despite the North having a higher demand. This skewed allocation of funding for public health programs only worsens the existing health inequities faced by Northern Ontarians.

Mad Studies

The Mad Studies lens provided an opportunity to better understand how people with mental illnesses and addictions have been treated poorly in the past, and how they still face discrimination today. Brückner (2021) suggests that the criticism of the psychiatric model of care has been ongoing since 1870, during which "lunatics' rights activism" was common in Europe (Brückner, 2021, p. 92). These movements acted as precursors to the grassroots initiatives, Mad activism and political lobbying that exists today (Brückner, 2021). My findings about the opioid crisis in the Ontario context revealed that the Provincial government rejected the social model of health when they introduced their new CTS model, which instead promotes rehabilitation and medical treatments for addictions. So, five decades later, there is still a fight against policy makers to reject the medical model as the only form of health care delivery, and consider the benefits of an alternative, social model. Moreover, my research showed the only time people with mental health difficulties have a voice is when they collaborate to form advocacy groups. For example, after many years of rigorous advocacy work, VANDU now attends provincial and federal meetings regarding drug policy and mental health. These findings indicate that overall, a majority of marginalized people with mental health challenges are still discriminated against, and usually do not have a say in the design and implementation of the services they will be using.

Discussion

In this paper, I reviewed activism and politics surrounding the opioid crisis in two provinces: British Columbia and Ontario. My research has revealed that in both provinces, grassroots groups have been enablers of drug advocacy and harm reduction policy. In British Columbia, VANDU's work cannot go unnoticed, as their dedication and passion to make a difference was the beginning of the powerful drug activism movement in Canada. By inspiring other advocacy groups in Ontario (e.g. THRA) VANDU's work is recognized nationwide. Their programs included alley patrol, syringe exchange and SIS amongst other services in the DTES. Similarly, THRA's and TOPS' grassroots work in Toronto has also made a positive impact on the lives of people who use drugs through the Moss Park OPS. Overall, I argue that the activism from VANDU and THRA was the main driving force for harm reduction initiatives, both sanctioned and unsanctioned, in British Columbia and Ontario. Whether the Provincial government provided support or not, communities of people who use drugs still came together to advocate for accessible harm reduction programs.

In addition to providing a better understanding of the role of activism, this research also revealed that a difference in political values acts as a major barrier to implementing harm reduction services. When comparing British Columbia (Liberal) to Ontario (Conservative), it is evident that the Government of British Columbia was much more supportive of harm reduction initiatives than the Government of Ontario. This difference is noticeable when we compare the different ways each province reacted to the opioid crisis. Shortly after Vancouver declared a state of emergency due to high

opioid-related death rates, the Provincial government took action by including harm reduction in its *Four Pillars of Drug Strategy* and urging the implementation of harm reduction initiatives. A combination of political support from the Federal and Provincial government (and grassroots activism) led to the implementation of INSITE in 2003. On the contrary, despite the apparent need for harm reduction services, the Government of Ontario rebranded the already-successful SCS model into the CTS model, making it more challenging for municipalities to develop SCSs amongst other harm reduction services. As a result, smaller communities (like Sault Ste. Marie) that desperately need harm reduction services are struggling to attain them. Moreover, the political barriers in Ontario also include poor resource distribution, as a majority of mental health care funding is directed in the Southern region, leaving the North with little financial support. As explained above, this results in equity concerns for smaller communities with higher opioid-related fatalities. Therefore, this research emphasizes the role that provincial politics plays in preventing provinces from developing harm reduction initiatives like SIS.

In a different light, I argue that the Federal government has acted as an enabler (rather than a barrier) to ameliorating the opioid crisis through its policy making and support. The role of the Federal government is to develop guides for the nation's healthcare system under the *Canada Health Act*, including health care funding (Government of Canada, 2019). Because health care services and delivery fall under provincial jurisdiction, the provinces are responsible for distributing this federal funding to each health care sector (Government of Canada, 2019). For example, public health

initiatives, health promotion programs and all healthcare facilities (Government of Canada, 2019). So, we cannot blame the Federal government for a *lack of action* to address the opioid crisis, as their role appears to be minimal compared to the provincial governments'. My findings showed that the Federal government took action in several ways to encourage the provinces to adopt harm reduction practices, such as, exempting VCHA to be exempted from the *Controlled Drugs and Substances Act*, adopting harm reduction in the *Controlled Drugs and Substances Act*, addressing the severity of the crisis in the *Joint Statement of Action to Address the Opioid Crisis* (2016), and approving class exemption for provincial OPS while SCS were still being developed.

To reiterate, the purpose of this research paper was to examine the differences and similarities in political support and activism in British Columbia and Ontario to gain a better understanding of the enablers and barriers to implementing harm reduction. Overall, it is clear that political support from the Federal government and Government of British Columbia act as enablers of harm reduction, but unfortunately, the Government of Ontario is still lagging behind, acting as a barrier to ameliorating the opioid crisis. Both provinces displayed noteworthy activism that played important roles in enabling harm reduction initiatives. The activism in British Columbia appears to be more rigorous than Ontario, but this may be because Vancouver has been involved in the war on drugs for over two decades, so VANDU is now well established. Ontario's THRA and its derivatives have made important contributions to provincial drug activism, but unlike British Columbia, Ontario does not have the political support to bolster their ongoing activism.

Future Suggestions

Short-term, I wish to see SIS implemented in communities that demonstrate high demand (i.e. Sault Ste. Marie). Evidence-based research has indicated that they are a successful tool to prevent opioid-related overdoses, which is needed to slow the growing rate of fatalities in Northern Ontario. I urge the Government of Ontario to streamline the SIS application process for these communities, and reallocate funding for mental health resources in an equitable manner.

In addition to short-term suggestions, I argue there is a strong need for more ongoing intersectional research about the complex relationship between mental health, addictions, homelessness and the opioid crisis. Through my research, I noticed there is a lack of literature that addresses how ethnicity, race, gender and age intersect to generate health disparities unique to certain populations. Future studies should consider the specific mental health services needs of Indigenous Peoples, LGBTQ+ groups, and racialized minorities, as they likely differ from non-marginalized populations. Moreover, research from Russell et al., (2019, 2020) has provided an understanding of the harm reduction service needs of youth who use drugs in Northern Ontario, however, I wish to see more research conducted in the North, as they have their own unique set of barriers compared to the South. Besides the literature from Russell et al., (2019, 2020) there appears to be an overall lack of research focused in the North. I argue that this ongoing research is needed, especially because the service needs of vulnerable populations are not static—rather—they change as time progresses. For example, the needs of people experiencing substance use disorders are much different now than pre-pandemic.

Therefore, social and health care services must develop as the needs of the population changes. And, the only way to understand these ever-changing needs is through ongoing research.

Furthermore, I argue that there is a need for more experiential knowledge in mental health and addictions research and policy making. In his (2010) article, Taggart explains that experiential knowledge is provided by individuals who have experience with Madness, mental health challenges or the use of mental health services. Involving individuals who will be using mental health services in the research process provides a chance to break the cycle of epistemic injustice, critique the traditional medical model of mental health, and encourage a bottom-up approach to research and policy making. In-turn, this allows people experiencing addictions to have a voice in important decisions that affect their health.

In addition to these short-term and ongoing goals, I hope to see long-term change to the political values in Ontario. My research has demonstrated the numerous ways the Provincial government acts as a barrier to adopting a harm reduction philosophy in our public health system. Until there is a shift in political leadership and values, the opioid crisis will only continue to worsen. As evidenced above, activism is powerful, but only to a certain extent. Without the political and financial support of the Provincial government, Ontario may be stuck fighting the war on drugs for many more years to come.

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Appendix

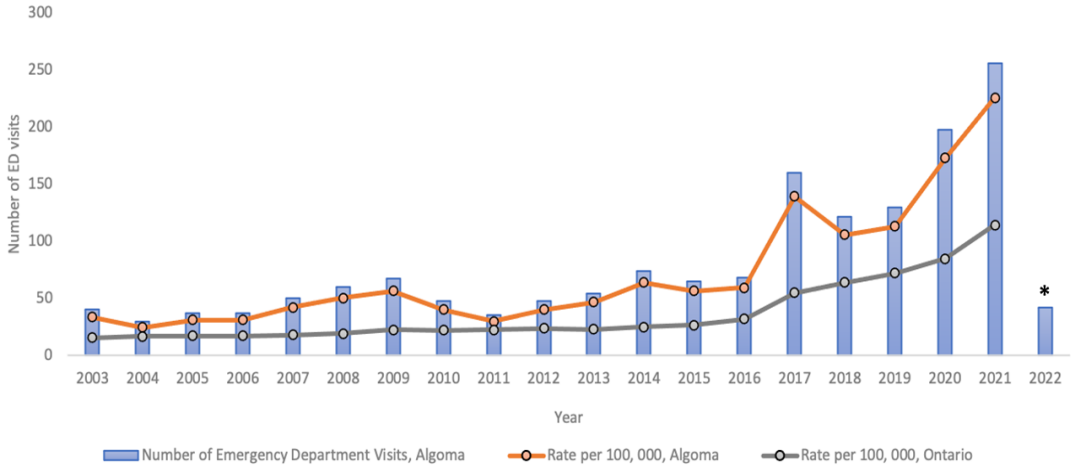

Figure 1. Graph displaying the number of opioid-related emergency department visits in the Algoma district, the rate per 100,000 in Algoma, and the rate per 100,000 in Ontario (APH, 2023).

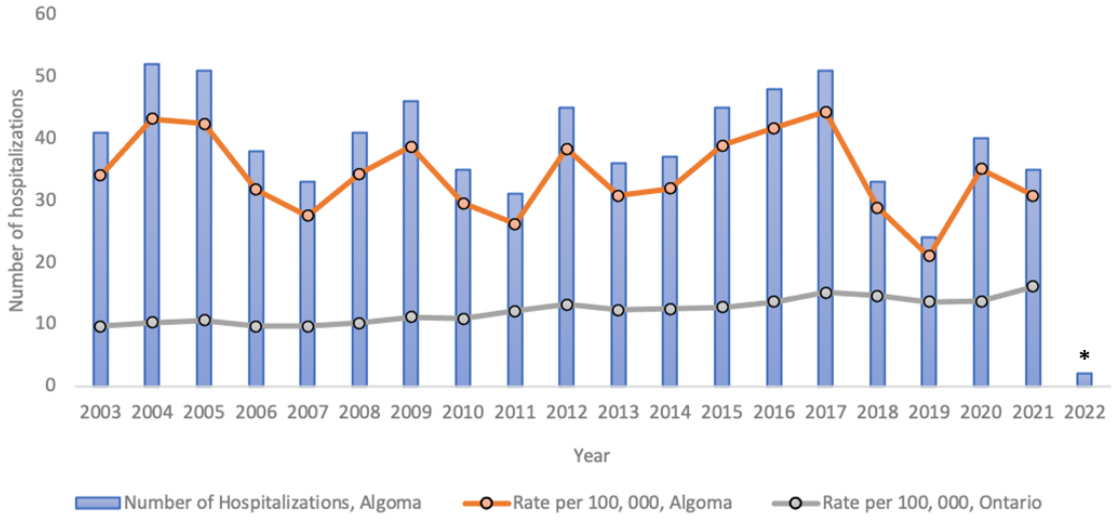

Figure 2. Graph displaying the number of opioid-related hospitalizations in the Algoma district, the rate per 100,000 in Algoma, and the rate per 100,000 in Ontario (APH, 2023).

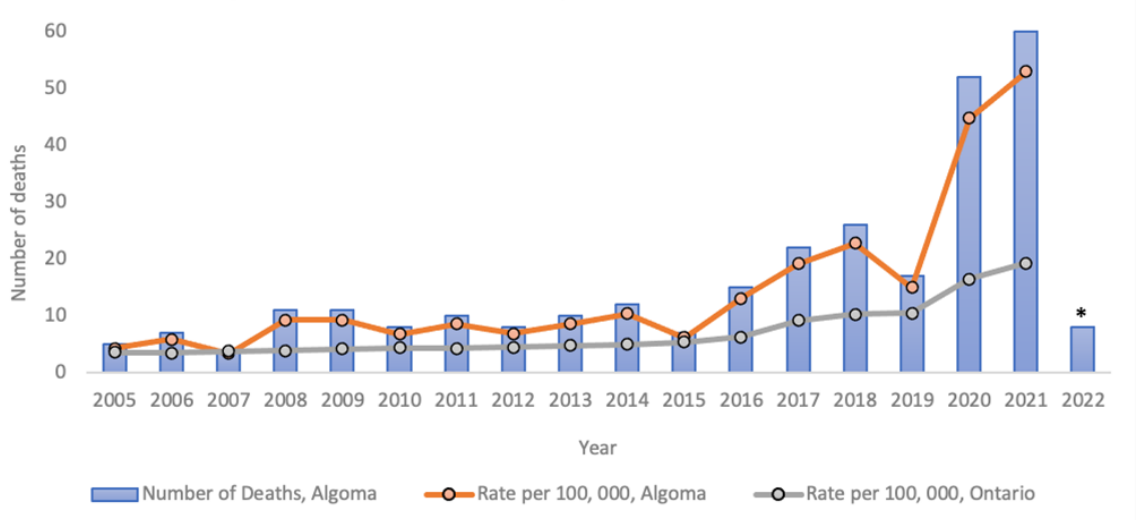

Figure 3. Graph displaying the number of opioid-related deaths in the Algoma district, the rate per 100,000 in Algoma and the rate per 100,000 in Ontario (APH, 2023).

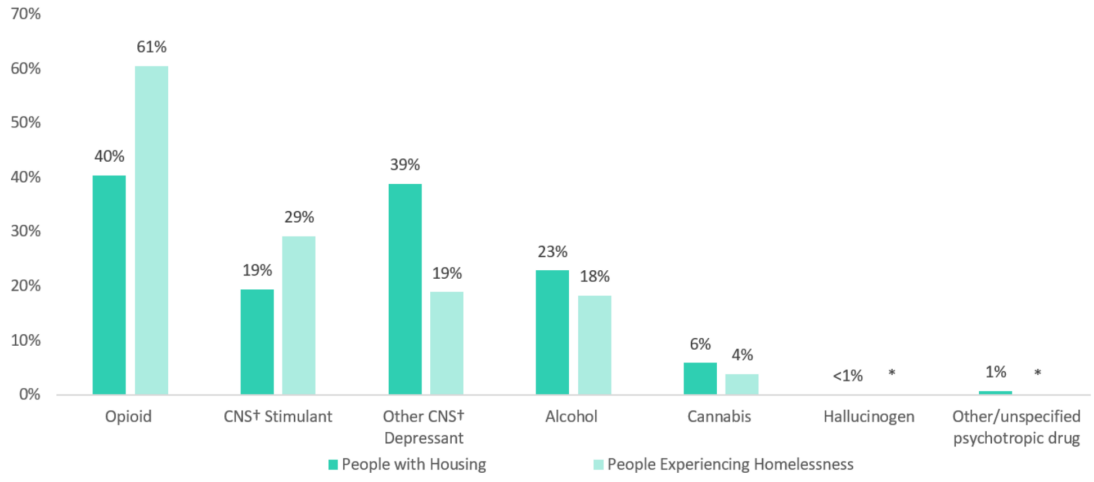

Figure 4. Bar graph displaying the type and percentage of substance-related hospitalizations experienced by people with housing and without housing in Canada from April 2019–March 2020 (excluding Québec) (PHAC, 2021).