Opinion, Opioid Overdose Crisis

SELECT STANDING COMMITTEE PRESENTATION, 2022

I would like to recognize that I am a visitor to this Coastal Salish Territory, and I would like to thank the First Nations for their hospitality. Thank you for this opportunity to present to the select standing committee on health as a representative from Westminster House Society and a citizen of British Columbia.

I want to qualify myself as a professional in the addiction recovery industry. I have a master's degree in business administration and extensive experience in the private and not-for-profit sectors, specifically addiction treatment recovery for 13 years and as Executive Director at WHS as for the past eight years.

I have read through the select standing committee proceedings transcripts. Because of time, I will speak briefly about Westminster House Society and ask that you visit the website or call us (604-524-5633) for more information. In summary, we are a 44-bed program for women and girls, specializing in the trauma-informed addiction recovery program continuum. Westminster House operates at the intersection of private and not-for-profit, and our services are for benefit. In the fiscal year 2021 – 2022, WHS operated our funded beds at a $245,712 deficit. We are licensed by the Fraser Health Authority and are in the process of obtaining CARF accreditation.

The program is a biopsychosocial modal and accepts all Medication Assisted Therapies (MAT), providing individuals are group-ready and not intoxicated from their medication. We have an onsite addictions doctor and access to psychiatric supports once per week – both services are retained by WHS funds in addition to MSP. WHS has a holistic-social approach, and similarly to my colleagues at the Last Door, our goals are to build a recovery capital supporting human, physical, social and cultural aspects of wellness, and it is at the forefront of our services. We utilize peer support and 12-step-based programs. Our wellness model also includes acupuncture, yoga, qi gong, massage, exercise programs and cultural experiences and groups. We also utilize onsite Registered Clinical Counsellors and Nursing services at our cost.

In addition to the 28 treatment beds, we have 14 funded solution-focused recovery housing spaces for women to live after completing 90 days of treatment as part of the program continuum. The recovery units are abstinence-based, and the women residents must be engaged in building recovery as part of their aftercare plan; this accountability directly supports their recovery. During the aftercare continuum, the women have access to educational opportunities, volunteer work and job placement because of our efforts to fundraise.

We track outcomes utilizing instruments including My Recovery Plan, which aims to evaluate recovery capital in addition to the Fraser Health evaluation tools. Recently we have implemented systems to collect benchmark data from our stakeholders.

Our staff team is trained in mental health first aid, basic counselling, naloxone training, and trauma-informed care. In addition, our clinical staff team are CACCF certified addiction counsellors with diplomas in counselling and degrees in phycology. In summary, we are well equipped to treat addicted individuals.

However, we have new, urgent needs that need to be addressed, specifically mental health challenges. For example, the opioid overdose epidemic brought on a host of mental health issues for women, including the trauma of overdose, death, and near-death experiences, as well as cognitive problems resulting from non-fatal overdoses that affected an individual's brain due to lack of oxygen. For example, we recently treated a woman who overdosed 17 times in one month.

In addition, the COVID 19 pandemic brought on mental health challenges in women, including trauma caused by fear and isolation, anxiety, and depression.

Accessing psychiatric support for evaluation for women who attempt and threaten suicide, or engage in brutal self-harm episodes, is impossible and they are not adequately evaluated in the hospital setting. For example, last year, we had a 19-year-old girl who engaged in self-harm and was taken to the hospital. She was released 3 hours after being stitched up; we were asked to pick her up because “she was not a danger to herself or others.” However, when she arrived back at the facility, she jumped in front of a moving car.

Despite my expertise and ability to access resources, I am also a person who has lost family members to the disease of addiction. My family member relapsed on alcohol at 18 months clean and sober. Unfortunately, her disease progressed, and she was found dead six months later from a "heart attack" caused by fentanyl poisoning. While we sat in the hospital for five days, waiting for our loved ones to say goodbye and donate her organs, we learned (from the ambulance) that she had been admitted to the hospital **twice in less than a month from a drug overdose**. My personal experiences, as horrific as they are, are not uncommon stories to hear in my profession. Families are desperate, and so are we.

I would like now to the best of my ability to answer your questions. What actions should the government take to address the ongoing overdose and drug toxicity crisis and how services can be improved: through accountability, messaging and wrap around services.

ACCOUNTABILITY

I mirror the options of my colleagues that stigma and discrimination are relevant factors in the current crises. But I urge you to consider another realistic contributor that is not discussed openly for fear of retribution.

Many individuals use it alone because they don't want to share their drugs. This is one facet of the baffling nature of addiction.

Additionally, some individuals are willing to risk overdose and their lives and take poisonous drugs intentionally. Many don't want a safer supply except sell it to obtain a poisonous drug supply. Drug addicts are selling Delaudid and Hydromorphone to obtain poisonous drugs.

Another fact is that many use the supply of MAT, to maintain a somewhat functioning level. But unfortunately, they then seek out poisonous drug supplies intentionally to get high. The opposite of addiction is connection. Experience has shown that when recovering addicts have committed to connect with others at 12 step meetings and other relapse prevention groups, they feel a life-changing connection and thus, their recovery is strengthened. In doing so, their accountability and confidence increase.

PURPOSE AND ACCOUNTABILITY

Addicts need a purpose, and part of the safer supply and MAT program must include a dissuasion tactic. Individuals engaged in these programs must be held accountable to work or school. If they cannot attend work or school, then a potential solution is to attend *somewhere to be accountable*.

There are many free services not utilized effectively by the government, such as 12-step-based fellowships. At a 12-step-based fellowship, there is a chance that an individual in active addiction could be influenced by recovery. For those opposed to the 12-step-based fellowship, consider Smart Recovery, Life Ring or a solution such as mandated in-person counselling or in-person or group program in their community. There has been talk for over 5 years about opening recovery community centers that have still not materialized.

If addicts are not accountable to their treatment program, then it is not working – we have to start accepting that. We must try something else. We won't give up. You can't leave these people to fend for themselves; they are intoxicated and unable to make sound decisions.

MESSAGING

We have complicated factors in BC with illicit drug deaths. The problem is hard to solve but is **addressable** and **can** be resolved with systems, processes and accountability. Addiction is not that complex, meaning it doesn't have many unknowns. Remission from the disease often requires several rounds and pathways of treatment.

Some studies point to deaths in which methadone was the cause of death. Yet, there is no recently published data regarding the toxicology of the death and harm done by the increasingly toxic and unpredictable illicit supply of drugs. Seemingly because of the accountability for treatment decisions that have been made – we are too far down the rabbit hole.

According to the BC Coroners Service, toxic drugs have claimed the lives of more than 150 British Columbians, **daily**, for 18 consecutive months (cited in February of 2022). The statement from the coroner asking people using substances to "exercise great care, use only a small amount first, and make sure someone is nearby" is almost comical to people who have

experienced addiction. However, the coroner's statement only lends itself to recovery advocates' argument that the professionals leading the charge are grossly out of touch with the realities of addicted individuals who are intelligent, cunning and powerful individuals who will stop at nothing to get what they want.

For example, research on Social Marketing messaging (not to be confused with social media marketing) that aimed to decrease harm from the consumption of alcohol concluded that the patronizing approach (of social marketing) that applied negative messaging, such as shame and guilt, influenced behaviour; because the appeal created a sense of discomfort that caused a reaction to reduce the negative feelings. Therefore, patronizing messaging is an ideal approach to reach the demographic of youth and male construction workers who are at significant risk and are a demographic needing urgent help.

The "Stop Overdose" campaign only states the obvious and has no emotional appeal. I argue that the current messaging, including the messaging from the coroner, is weak and mostly ineffective.

We are entering a dangerous time, and messaging s critical for prevention. We cannot imply that using drugs is at all safe or accepted. I suggest effective *messaging utilizing social marketing campaigns to change behaviour.*

Side bar: We treat youth as young as 14 years' old who do not understand the consequences of drug use because there is no drug awareness, and frankly, they have no fear.

Based on the patronizing approach of social marketing, I have some examples of effective social marketing, however, I will mention one:

Examples of messaging to change behaviour and increase prevention:

1. Using drugs builds a faulty foundation (construction/male)
    a. Imagery of a construction worker overdosed on site falling off a building
2. **The price of crystal meth is your teeth (youth ad)**
    a. Imagery of what youth addicts could look like from using drugs
3. Drug dealers need a consequence.

a. Consider the MADD advertisements that are very powerful with imagery of being arrested.

Social marketing messaging is appropriate to illustrate the consequences of addiction and subsequent bad behaviour and emphasis solution-focused messages that promote long-term outcomes.

Ideally, if you are on drugs and need help, go to the hospital. British Columbians must be able to expect heath care and solutions in an emergency situation.

MISSED OPPORTUNITIES

Harm reduction advocacy groups stigmatize recovery and discriminate against abstinence. These groups have victimized addicts; they do not need sympathetic pity and concern for their sufferings or misfortunes; **they need help**. There is a fine line between compassion and enabling. Unfortunately, a percentage of individuals suffering addiction and overdoses humiliate themselves publicly, engage in extreme self-harm and participate in public drug use and crime.

In most instances, individuals who are hospitalized with a critical addiction issue, such as a mental health crisis, severe withdrawal or overdose, are labelled addicts; the box is ticked, and the individuals are released almost immediately. Health professionals fail to consider that once an individual is administered Narcan, they go into immediate withdrawal. Wrap-around services are needed to take advantage of the immediate opportunities, while they are still in acute care, to support the individual out of the grips of addiction and provide instant long-term solutions by nudging them toward the desired outcome.

Over the course of a decade, Leslie accessed all pathways of treatment. Leslie relapsed and overdosed and was admitted to Surrey Memorial Hospital, where, according to her family, she was almost immediately released. Unfortunately, she used the pay phone in the lobby of the hospital to call her dealer. When the family arrived at the hospital they learned that she overdosed and died in the parking lot of that hospital.

In the transcript from June 21, it was asked to explain how people who go to treatment, come out, and they're at more risk and die. I question why human beings who access a hospital for an overdose die, or overdose, again and again, affecting their mental health and the integrity of our health care system. You would expect that if a British Columbian access a hospital, they will get help for their health issue.

So to answer the steering committee question about *improving care and how government and institutions improve services, support, and resources in response to the ongoing overdose and drug toxicity crisis*, the answer is to circle back to the start of an individual's process and provide wrap-around services and opportunities to access services right from the start of the cycle. **The province cannot continue to tick the box and send people back to the grips of addiction.**

Circling back to the concept of Social Marketing: Nudging is a social marketing concept that proposes positive reinforcement and indirect suggestions to influence behaviour and decision-making by nudging individuals towards a preferred goal such as human health and well-being. For example, the province should consider investing in nudging strategies to reduce harm by dissuading individuals into support for adequate assessment. Nudging strategies will help influence treatment choices, improve outcomes, reduce damage to the province's reputation, and reduce drug overdose and related deaths.

There are many textbooks and examples of the theory of Nudging. The health authority is positioned as an expert. It can use wrap-around services to redirect people to conform to the desired behaviour by developing the conditions, social systems and environments in which people prefer to make choices for their benefit. The experts can nudge people toward mandated solutions – but it won't happen in 2 hours, 48 hours or even 72. My 13 years of experience in this sector concludes that nudging individuals to make choices for their benefit could take up to 2 weeks.

WHS has a two-week stabilization period for this exact reason.

PRIORITIZING FUNDS

I am not going to comment on the provincial budget; however, I am sensitive to the issues - there is no money for health care – and everyone is asking, and not enough to go around, we are all fighting over the hand-me-downs.

However, by auditing the health care expenses and studying solution-focused recovery-orientated systems of care (ROSC), I would urge the steering committee to consider that 2 weeks of assessments will save taxpayer dollars by avoiding emergencies, remittance into hospitals, and death. Additionally, again, there are many recovery services that are free.

Also, most importantly, we do not have a bed shortage in BC, we have a funding shortage. Therefore, I urge the government to utilize infrastructure that is already existing. Continuing to build infrastructure – is costly, and history would demonstrate that many of the new structures are not worth the investment.

HOUSING SECOND

Simply: The mental health act urgently needs to be reviewed, and subsequent placement of people into SRO. Walking through some of our poorer neighbourhoods can be easily mistaken for a scene from a zombie apocalypse movie with individuals unable to control their uncoordinated movements, stricken with flesh wounds and disease. Questionably, the treatment of this demographic of people is inhumane. Individuals often defecate on the streets, inject drugs into their bodies out in the open, and lie unconscious on the sidewalk. What kind of message is that for our societies, for our children?

Many addicts in addiction can't remember to eat, sleep, pay bills, and even use a phone. Help is not offering prescriptions, hotel room keys, paraphernalia, and saying good luck. Instead holding individuals accountable to their treatment pathway, whatever pathway they choose. Help is accountability for the medications prescribed, dispensed, administered and ingested.

Help is teaching people how to live before giving them a key.

Recently a study in Canada concluded that OAT and psychosocial treatment programs have mainly operated independently. However, the opioid crisis has increased recognition of gaps between these services and the potential for better integration between them. Integration is expected and enforced in the bed-based addiction treatment industry, but integration is often ignored by those whose sole purpose is to administer harm reduction.

Gap exists because of a lack of understanding of what it's like to be addicted. I argue that the research in the province of SUD is influenced because the research finding will benefit the funders; they will get something to gain from its outcome. **The province underestimates the crafty and manipulative behaviours of many addicts in addiction**.

Producing evidence

A review of data on overdose toxicology, including drugs meant to reduce harm, would signal an urgent need to change the provincial response to addiction recovery because, despite all the medical interventions in British Columbia, the illicit drug problem worsens. Additionally, investing in the tools available to track addiction treatment and recovery such as My Recovery Plan could be deployed in every license or registered addiction treatment, harm reduction, and recovery service regardless of the pathway – I'm baffled why we cannot agree to collect evidence from all pathways and track patients and clients throughout their process. This is the only way we can make informed intelligent decisions.

I suggest that the potential reason why addicts with opioid dependency cannot recover is because of the historical pharmaceutical interventions (see brief history of addiction treatment blog) and the less obvious but important gaps of not understanding how individuals think and behave when intoxicated.

Prevention in the form of Social Marketing and Nudging are steps recommended as well as wrap-around services for individuals who are seemingly trapped in the cycle of addiction – and when the tiny door to recovery opens, it is closed just as fast by the principle of reducing harm.

The mental health act needs to be reviewed. People at risk of death should not have a choice to keep using illicit drugs. Period. It was too expensive. It is not solution-focused and only delays the inevitable.

No matter what happens in the forum, there has to be an understanding that I am not the expert, nor are you. The experts are the people who have recovered and know the way out.

Author, Susan Hogarth, MBA

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AN ADDICT FELL IN A HOLE AND COULDN'T GET OUT.

A businessman went by and the addict called out for help. The businessman threw him some money and told him to buy himself a ladder. But the addict could not buy a ladder in this hole he was in.

A doctor walked by. The addict said, "Help! I can't get out!" The doctor gave him some drugs and said, "Take this. It will relieve the pain." The addict said thanks, but when the pills ran out, he was still in the hole.

A well-known psychiatrist rode by and heard the addict's cries for help. He stopped and asked," How did you get there? Were you born there? Did your parents put you there? Tell me about yourself, it will alleviate your sense of loneliness." So the addict talked with him for an hour, then the psychiatrist had to leave, but he said he'd be back next week. The addict thanked him, but he was still in the hole.

A priest came by. The addict called for help. The priest gave him a Bible and said, "I'll say a prayer for you." He got down on his knees and prayed for the addict, then he left. The addict was very grateful, he read the Bible, but he was still stuck in the hole.

A recovering addict happened to be passing by. The addict cried out, "Hey, help me. I'm stuck in this hole!" Right away the recovering addict jumped down in the hole with him. The addict said, "What are you doing? Now we're both stuck here!!" But the recovering addict said, "Calm down. It's okay. I've been here before. I know how to get out." Author, Unknown