



Submitted by:

Canadian Society of Addiction Medicine – La société médicale canadienne sur l’addiction (CSAM-SMCA)

Brief Submitted to the House of Commons Standing Committee on Health

Re: “Opioid Epidemic and Toxic Drug Crisis in Canada”

November 4th, 2024

Background

The Canadian Society of Addiction Medicine (CSAM) applauds the House of Commons Standing Committee on Health undertaking a study of the Opioid Epidemic and Toxic Drug Crisis in Canada. As has already been expressed by the variety of briefs and witnesses, this is a complex and tragic public health emergency with multiple viewpoints and considerations. It is also a topic of great urgency to Canadians, with over 47,000 lives lost to opioid-related toxicity since 2016¹.

CSAM is eager to support a submission from the national perspective of addiction medicine providers. Evidence-based policy requires expert and specialist points of view along with the added insight of the etiology and epidemiology of those at risk of, or living with, substance use disorders (SUDs).

SUDs are best understood as chronic medical conditions, with multiple biopsychosocial factors underlying their development, often in adolescence or early adulthood, not through a moral failing or a criminal justice lens. A previous estimate of lifetime prevalence of a SUD² in Canada is shockingly high, at 21%, or over 1 in 5 Canadians. Additionally, according to CIHI³, SUDs were the 5th most common cause of hospitalization in 2021-2022, reflecting a substantial impact on an already taxed medical system. Despite this, the CCSA Canadian Life in Recovery Survey⁴ reported over 50% of those in recovery have never destabilized, which has been seen in similar surveys of individuals in recovery in the United States, United Kingdom, and Australia.

We know that treatment access is key to helping those living with SUDs recover while reducing the burden and cost to the healthcare system. Although Canada's healthcare system is purported to be universal, the Canada Health Act only covers hospitals and doctors, a small part of the treatment pathway. Additionally, there is substantial variability in the extent to which evidence-based interventions are funded and supported across the country.

1. Decriminalization

There is consensus that substance use should be treated as a health issue and many would agree⁵ this includes the decriminalization of the possession of drugs for personal use. It is important to distinguish between legalization and decriminalization. Legalization means the sale of the drug is legal and the government controls sales through regulation. Decriminalization of possession for personal use means it is still illegal to sell the substance but it is legal to possess a small amount for personal use, thereby removing the punitive and stigmatizing approach to people who use drugs.

¹ <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/>

² <https://www150.statcan.gc.ca/n1/en/pub/82-624-x/2013001/article/11855-eng.pdf?st=K51HASFu>

³ <https://www.cihi.ca/en/hospital-stays-in-canada-2021-2022>

⁴ <https://www.ccsa.ca/life-recovery-addiction-canada-technical-report>

⁵ https://angusreid.org/wp-content/uploads/2021/03/2021.02.24_Opioid_Dependence.pdf

It is significant that both the medical community (including CSAM, CMA, CFPC, CAEP) and law enforcement (CACP) support decriminalization to deal with the harms of substance use. Many lessons can be learned from the efforts of decriminalization in Oregon and British Columbia, and successful implementations internationally. Simply focusing on one piece of drug policy without access to treatment, without enforcement, and without prevention may be more harmful than beneficial. That does not mean it will not work, but rather we need to take a systemic approach and implement all safeguards and processes to create a system of care for all to access, based on the four pillars of substance use policy: prevention, harm reduction, treatment and enforcement.

The reasons for Oregon⁶ repealing decriminalization and BC⁷ making significant changes were primarily concerns about public drug use and public safety. CSAM strongly supports decriminalization of drug possession for personal use and eliminating the criminalization of addiction in the setting of a robust prevention program, accessible harm reduction services, enforcement, and a treatment system of care available to all Canadians.

We recommend that the federal government work with provinces/territories to pursue decriminalization, modifying approaches as necessary to balance the safety concerns of consumers, families and society. We further recommend that the federal and/or provincial/territorial governments should ensure that they enact legislation prior to decriminalization to restrict the use of currently illegal drugs in public places, similar to existing legislation prohibiting public use of legal substances.

2. Prevent/Delay use

SUD is a pediatric onset illness, with up to 90% of the cases developing during adolescence and early adult years. About 50% of the risk is genetic. Many youths with SUD have other mental health symptoms. Those who initiate use before 15 years of age are six times more likely to go on to develop an SUD compared to those who initiate use over 21 years of age.

We recommend that the federal government support public health and school programs to prevent/delay initiation of substance use. Age-appropriate education should not be limited to education about the toxic drug supply and harm reduction, but should include education about SUDs to reduce stigma and raise awareness regarding when students, or their loved ones, may be at risk. We also advocate for more mental health resilience training so that our schools become supportive environments that promote mental health and well-being, empowering young people to overcome challenges and thrive in their personal lives. Further, we recommend rollout of programs to identify at-risk youth and provide them targeted interventions including social supports and programming known to protect against substance use, similar to those in other jurisdictions (e.g. Icelandic model, Preventure).

⁶<https://www.opb.org/article/2024/09/01/oregon-starts-drug-possession-recriminalization/#:~:text=Oregon%20has%20ended%20its%20experiment,again%20considered%20a%20misdemeanor%20crime>.

⁷ <https://news.gov.bc.ca/releases/2024PREM0021-000643>

3. Update the Canada Health Act

Following our colleagues from the Canadian Mental Health Association⁸, we agree it would “simply be inaccurate to call our health system universal, or comprehensive”. The Canada Health Act only covers treatment for those with chronic complex illnesses, including SUDs, via doctors or hospitals. This means that many first-line, evidence-based treatments are not covered under the Act. This is leaving our most vulnerable lacking access to skilled professionals (including psychology, social work, physiotherapy, occupational therapy, peer support, nursing), programs and supports that have been shown to aid recovery.

We recommend that the federal government update the Canada Health Act to cover the healthcare needs of people with SUDs and other mental health conditions to provide a truly universal healthcare system for Canada, or create a new act in order to do so.

4. National Pharmacare Program Coverage

We applaud the work of the federal government as we agree all Canadians should have access to medications that can save lives, especially our most vulnerable and marginalized. The best evidence for reducing death for those living with an opioid use disorder and/or at risk of a toxic drug overdose are medications for opioid use disorder⁹. Access to medications can be a significant barrier to treatment for this vulnerable and marginalized population, and coverage varies across jurisdictions.

While there are several medications that can be beneficial for reducing substance related harms, we recommend the federal government add, at a minimum, first-line medications for Opioid Use Disorder to the national Pharmacare formulary including buprenorphine (including sublingual tablets, film, and injectable extended-release formulations) and methadone. Further, we recommend the federal government address barriers preventing the Health Canada approval of long-acting injectable naltrexone as an alternate treatment option; once available, injectable naltrexone should be added to the national Pharmacare formulary.

5. Canadian Mental Health and Substance Use Health (MHSUH) Task Force

Following the internationally recognized Canadian Pain Task Force¹⁰, we recommend that the federal government build on and expedite the implementation of The MHSUH Standardization Roadmap¹¹ by establishing a Canadian MHSUH Task Force to provide advice regarding evidence and best practices for the prevention and management of SUDs in Canada. The Task Force will develop and enact a national action plan

⁸<https://cmha.ca/brochure/request-to-meet-to-address-the-exclusion-of-mental-health-and-substance-use-health-care-services-in-canadas-public-universal-health-care-system/>

⁹<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032#:~:text=In%20a%20national%20cohort%20of,in%20overdose%20at%2012%20months.>

¹⁰<https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force.html>

¹¹ <https://scc-ccn.ca/resources/publications/mental-health-and-substance-use-health-standardization-roadmap>

for funding and treatment of SUDs that includes regional/provincial representation of experts. The Task Force would be mandated to:

- Ensure integration and alignment between health services that are federally and provincially funded, thus avoiding gaps in care provided in Indigenous communities;
- Assess how addiction is currently addressed throughout Canada;
- Conduct national consultations with experts, people living in recovery and people with lived and living experience, and families of those affected by SUDs and review available evidence to identify best and leading practices, potential areas for improvement, and elements of an improved approach to the prevention and treatment of SUD in Canada;
- Provide recommendations for the federal government to collaborate with provincial/territorial/municipal governments to ensure the establishment of accessible treatment-on-demand (ie. benchmarks for wait times to initiation of service) including withdrawal management services and flexible-length bed-based and community-based treatment services that are trauma informed, culturally relevant and evidence-based;
- Provide recommendations to ensure wide accessibility across Canada to evidence-based interventions shown to reduce harms related to substance use, including drug use supplies (e.g. needles, sterile water), intranasal naloxone, services (including supervised consumption sites, overdose prevention sites, drug checking, testing and treatment of blood borne pathogens); and
- Develop a framework, including research reporting standards, to support robust evaluation of innovations to address the toxic drug crisis.

Summary:

Thank you for your attention to the information provided in this brief. Most of our membership work with people impacted by SUDs on a daily basis. As such we have seen and continue to see first-hand the harms caused by the opioid epidemic and toxic drug supply. While a comprehensive plan to address this crisis will require a multi-pronged approach, we feel strongly that any successful response requires a coordinated addiction strategy addressing all four pillars of prevention, harm reduction, treatment and enforcement. We look forward to presenting to the HESA committee to provide further input and answer any questions that arise from this brief.

Description of organization:

CSAM (<https://csam-smca.org/>) was founded in 1989 by a group of physicians, scientists, and researchers who saw a need for a professional association that would represent the medical profession in the area of substance use disorders. Originally called the Canadian Medical Society on Alcohol and Other Drugs, it has evolved into a national organization of medical professionals, allied health workers, and scientists who are committed to helping Canadians understand, endure, and overcome SUDs.

Recommendations Summary:

1. **Decriminalization-** The federal government should work with provinces/territories to pursue decriminalization, modifying approaches as necessary to balance the safety concerns of consumers, families and society.
2. **Prevent/delay use-** The federal government should work with provinces/territories to support public health and school programs to prevent/delay initiation of substance use including mental health resilience training as part of curriculums. Further, the government should support the rollout of programs to identify at-risk youth and provide them targeted interventions known to protect against substance use.
3. **Update the Canada Health Act-** The federal government should update the Canada Health Act to cover the healthcare needs of people with SUDs and other mental health conditions to provide a truly universal healthcare system for Canada, or create a new act in order to do so.
4. **National Pharmacare Program Coverage-** The federal government should add, at a minimum, first-line medications for Opioid Use Disorder to the national Pharmacare formulary including buprenorphine (including sublingual tablets, film, and injectable extended-release formulations) and methadone, and work toward Health Canada approval and subsequent Pharmacare inclusion of long-acting injectable naltrexone.
5. **MHSUH Task Force-** The federal government should build on and expedite the implementation of The MHSUH Standardization Roadmap by establishing a Canadian MHSUH Task Force, whose mandate would include increasing access to evidence-based treatment for substance use disorders.