Final Report: A Public Health Approach to Substance Use

Survey of Public Health, Public Safety, Health and Social Service Professionals

July 2023

About CPHA

The Canadian Public Health Association (CPHA) is the independent national voice and trusted advocate for public health, speaking up for people and populations to all levels of government.

We champion health equity, social justice and evidence-informed decision-making. We leverage knowledge, identify and address emerging public health issues, and connect diverse communities of practice.

We promote the public health perspective and evidence to government leaders and policy-makers. We are a catalyst for change that improves health and well-being for all.

We support the passion, knowledge and perspectives of our diverse membership through collaboration, wideranging discussions and information sharing. We inspire organizations and governments to implement a range of public health policies and programs that improve health outcomes for populations in need.

Our Vision

Healthy people and communities thriving in inclusive, equitable, sustainable environments.

Our Mission

To enhance the health of people in Canada and to contribute to a healthier and more equitable world.

Table of contents

Acknowledgements

Report authors and staff involved in the project:

Dr. Tara Marie Watson- Associate Director, Research Program, Department of Family and Community Medicine, University of Toronto

Greg Penney- Director of Programs, CPHA

Kelsey MacIntosh- Senior Project Officer, CPHA

Sophie Chochla- Project Officer, CPHA

Alexie Kim- Project Officer, CPHA

Survey background and goals

This report is based on a survey designed and conducted as part of the four-year project, Normalizing conversations: Engaging public health, public safety and communities to build capacity for a public health approach to substance use. Launched in 2020 and led by the Canadian Public Health Association (CPHA), this project captures knowledge from stakeholders and organizations from public health, public safety and other allied sectors across Canada. A major project goal is to enhance knowledge and capacity in these sectors to implement a public health approach to substance use, including use of alcohol, cannabis, opioids and other psychoactive substances. This project has set out to achieve this goal by generating important new data and supporting the collaborative creation of usable knowledge products and capacity-building resources for professionals, practitioners and organizations, including new tools about reducing stigma associated with substance use.

The development of a national survey of public health, public safety and other health and social service professionals was motivated by the need to better understand key stakeholder beliefs and attitudes, knowledge levels, individual and organizational capacity, and access to information, resources and training about substance use. These needs have been informed by consultations and a review of current literature to identify knowledge, practice and policy gaps related to substance use experienced by a range of key stakeholders, such as public health and public safety professionals. Gaps that were identified include lack of stakeholder knowledge about harm reduction interventions and lack of awareness about the myriad impacts of stigma, limited implementation of evidence-based public health practices, and inconsistent substance use screening and interventions across specific populations (Livingston et al., 2018; Loheswaran et al., 2015; Lowis et al., 2019; Mahon et al., 2018; McNeely et al., 2018; Necyk et al., 2019; Nichols & Gringle, 2020; Reichert & Gleicher, 2019; Ross et al., 2018; Sightes et al., 2019; Venner et al., 2018).

Addressing gaps in knowledge about the impacts of stigma around substance use is especially important. Experiences of stigma, especially during interactions with health service providers, are commonplace among people who use substances, and these experiences contribute to numerous harms such as lower quality of care and access to health and social services (Biancarelli et al., 2019; Mendiola et al., 2018; Murney et al., 2020; Public Health Agency of Canada, 2020; Reichert & Gleicher, 2019). Efforts to reduce stigma – including initiatives that could increase open, honest and non-judgmental conversations about substance use – have therefore garnered increased attention and are becoming recognized as public health responses that would reduce harm and increase the well-being of people who use substances (Canadian Centre on Substance Use and Addiction, 2019; Public Health Agency of Canada, 2020). Building the capacity we need to implement comprehensive efforts to normalize conversations about substance use and reduce stigma requires an in-depth understanding of how multi-sectoral professionals and practitioners view substance use and their capacity to effectively respond.

Survey background and goals

CPHA's national survey also sought to generate new knowledge about how Canadian professionals and practitioners understand the meaning of a public health approach to substance use. While the term "public health approach" is used frequently in this context, it is often inconsistently defined and may even be used without a definition (Crépault et al., 2023).

How do people working in the health and social service sectors, especially those who work closely with those who use substances, interpret such an approach? CPHA has noted an absence of Canadian literature that captures understandings of and attitudes toward a public health approach to substance use among a broad range of professionals.

The online survey described in this report was designed by a CPHA research team to collect the data needed to inform our understanding of how Canadian professionals working in public health, public safety and other key sectors define and implement a public health approach to substance use.

In 2014, CPHA began developing its own definition of a public health approach to substance use (CPHA, 2014). Since then, this definition and, more broadly, CPHA's conceptual framework of public health have been updated to reflect important shifts in our understanding of key public health principles and practices (CPHA, 2017). While CPHA's definition of a public health approach to substance use continues to evolve, for the purposes of this national survey study, CPHA used the following definition:

> *A non-judgmental approach that seeks to maintain and improve the health of populations based on principles of social justice, attention to human rights and equity, evidence-informed policy and practice, and addressing the underlying determinants of health.*

The remainder of this report describes the methods used to develop, disseminate and analyze a national online survey of Canadian professionals and practitioners, provides the survey findings, direct quotes from respondents, and descriptions of key results grouped under thematic subheadings and concludes with a brief discussion and recommended next steps.

Methodology

During early survey development in 2020, the research team defined the target audience as public health, public safety and other health and social service professionals. This wide audience was meant to include, but is not limited to the following groups:

- Public health professionals (e.g., public health promoters, program planners, policy-makers and organization leaders)

- Health and social service and care providers (e.g., physicians, nurses, social workers, mental health and addictions workers, peer support workers)

- Public safety professionals (e.g., police officers, other first responders, correctional officers, criminal justice or court administration personnel)

- Other community-level professionals and practitioners who interact with and/or impact the lives of people who use substances

Survey development resources (Dillman et al., 2014; Krosnick & Presser, 2010; Schaeffer & Presser, 2003) were consulted to support the initial development of survey questions. The research team collaboratively drafted closed- and open-ended questions to assess the target group's knowledge, values and capacity about a public health approach to substance use. Draft survey questions were shared with and piloted by an Expert Reference Group engaged by CPHA for the larger project that includes people with lived and living experience of substance use, representatives from the survey's target audience and researchers.

Multiple survey drafts were reviewed and refined by the research team to ensure questions were clearly worded and avoided stigmatizing language. In some cases, research team members and the Expert Reference Group suggested use of certain phrases considered stigmatizing by some people (e.g., "lack of will-power" as a response option for a question about beliefs regarding why people use substances). Such terms were incorporated because of their common usage and to help ensure a range of beliefs and viewpoints could be captured. Final survey question formats included multiple choice, descriptive rating scales and open-ended questions.

Except for two initial survey questions about occupational sector and role, all questions included a "prefer not to say" option for respondents. The final online survey was designed using SimpleSurvey online survey software. (For more information on this platform, see http://simplesurvey.com/.)

Survey findings

A total of 1502 survey responses were collected; 461 surveys were incomplete, which left a remainder of 1041 completed surveys that were analyzed by the research team.

Demographic characteristics of survey sample

The largest proportion of respondents indicated they worked in Ontario (37%), followed by Alberta (19%), Quebec (12%) and British Columbia (10%). No survey respondents selected Northwest Territories, Nunavut, or Prince Edward Island as their location of work (**Figure 1**).
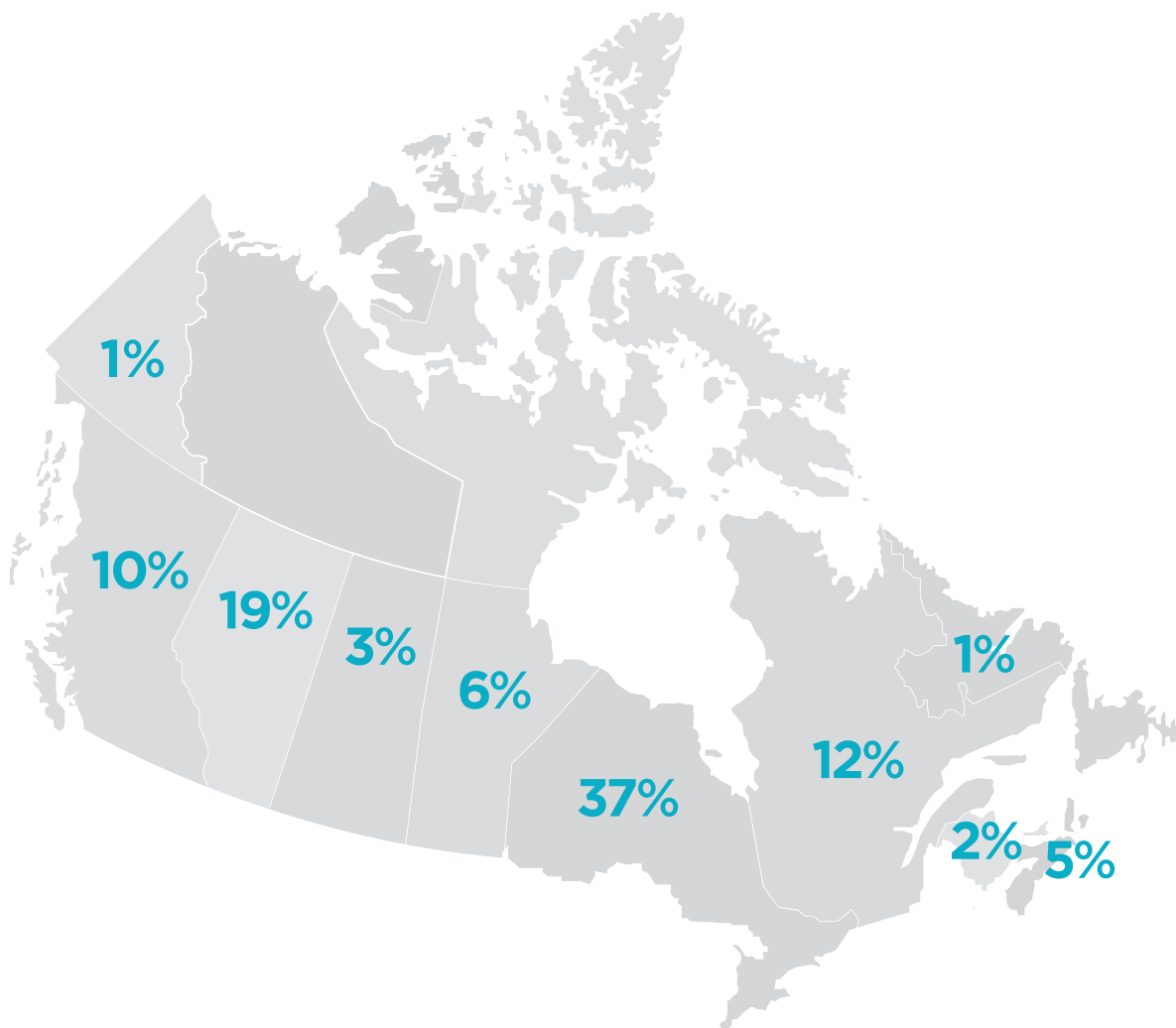
Figure 1: **Province or territory location of work**

Nearly a third (31%) of the sample indicated their work was at the local level, while similar proportions reported they worked at the provincial/territorial (22%) or regional (21%) level (**Figure 2**).
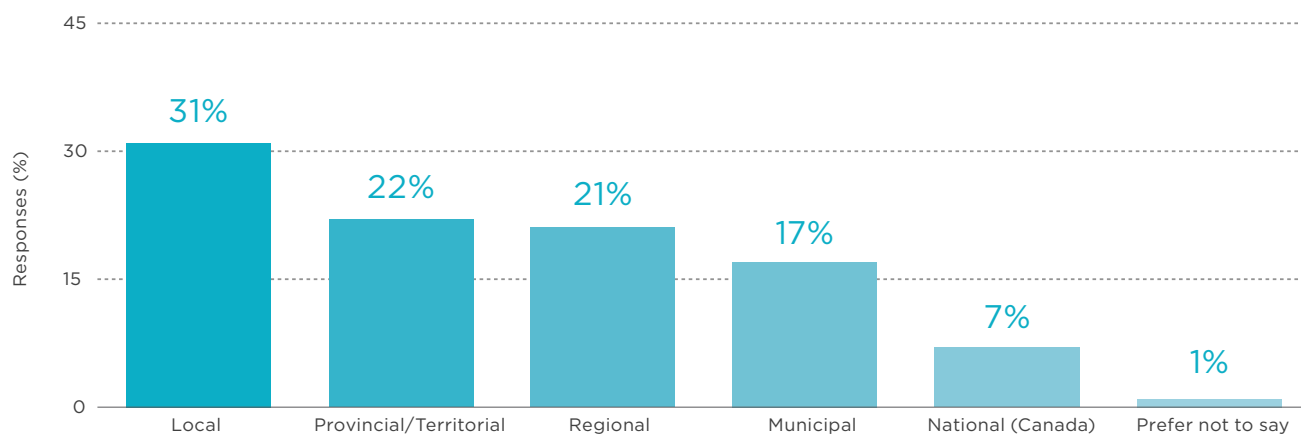
Figure 2: **Level of work**

When asked to select from a list of broad categories for type of sector, the largest proportions of respondents indicated they worked in health care (43%), followed by public health (23%), non-governmental organization (18%) and social services (18%). Note: many respondents selected more than one sector (**Figure 3**).
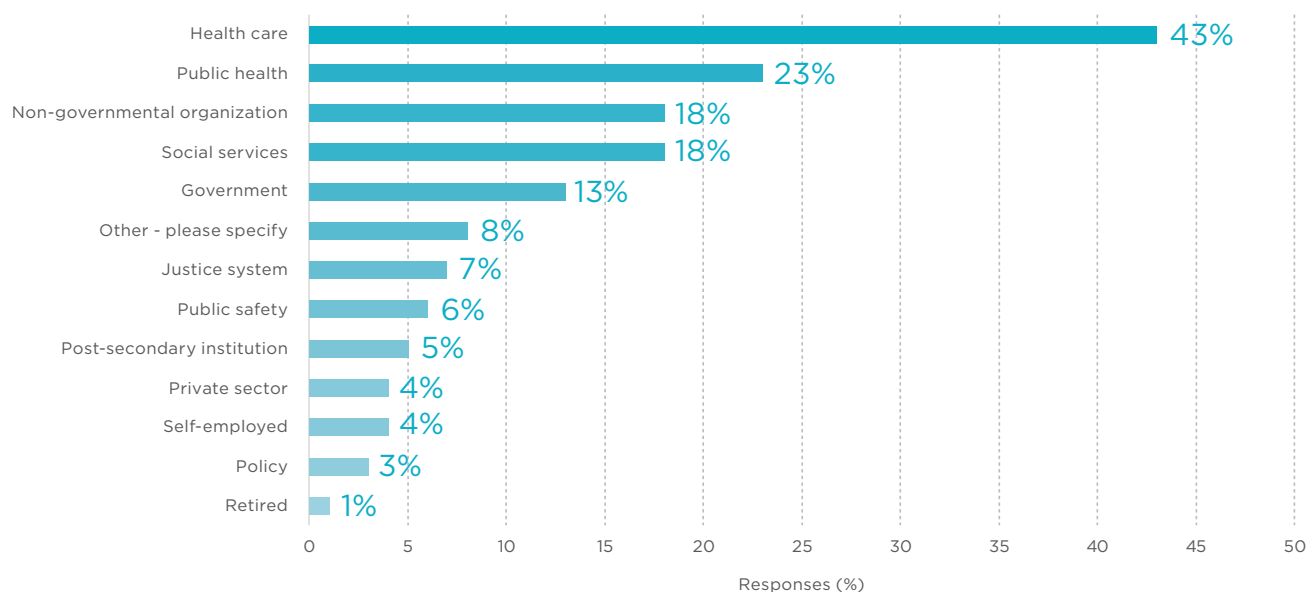
Figure 3: **Sector**

Similarly, respondents could select more than one occupation from a list of broad categories. The largest proportion selected social worker, counsellor, or other service provider (27%), followed by nursing professional (16%), other (16%) and agency leadership (10%). Other types of occupations specified and not shown in **Figure 4** include law enforcement officer, correctional officer, psychologist, lived experience advisor, student and educational employment service provider.
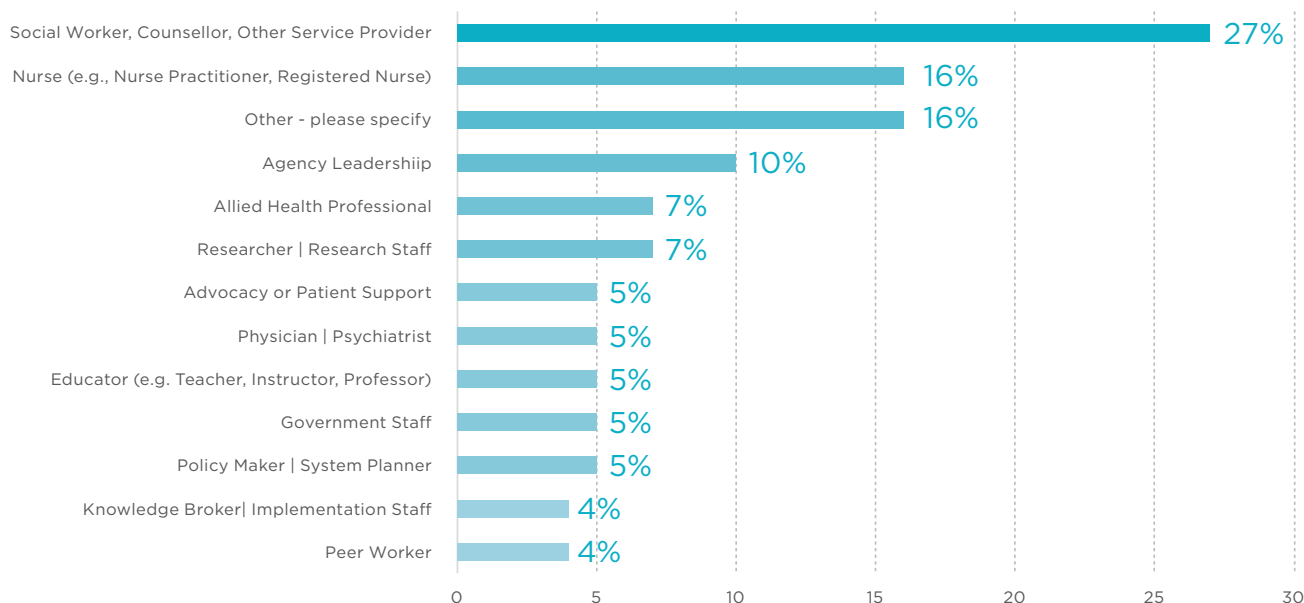
Figure 4: **Occupation**

Most respondents (27%) reported their age was between 35 and 44 years; 23% were between the ages of 25 and 34 years and 22% were between 45 and 54 years. Only 4% reported their age was 65 years or over and 3% were between 19 and 24 years (**Figure 5**).
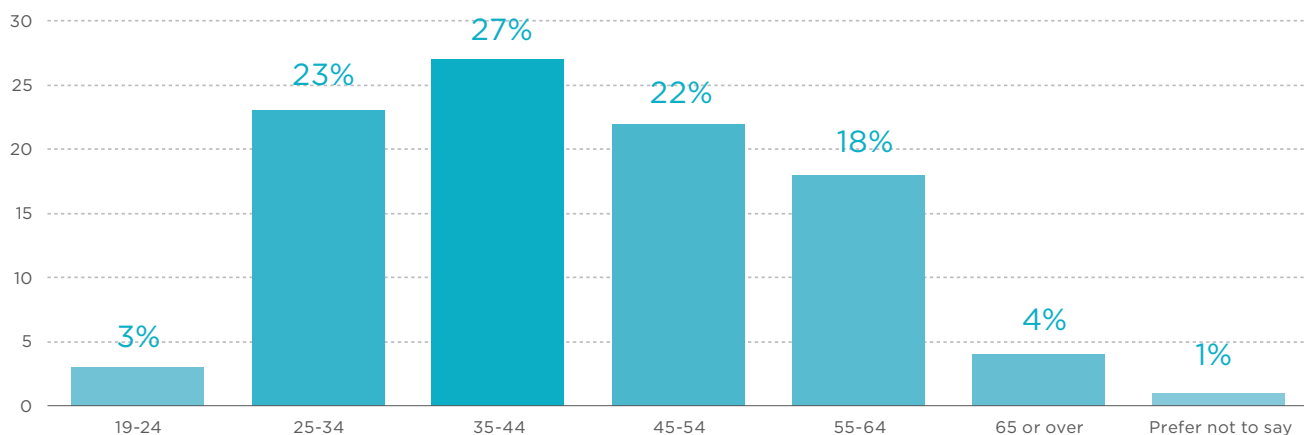
Figure 5: **Age**

The survey offered different gender identity options and respondents could select all that applied. More than half identified as women (67%), while the same proportion of the sample identified as men (22%) and cisgender (22%). Of those who selected cisgender, more respondents identified as cisgender women (12%) than cisgender men (3%). Fewer respondents selected identities of gender non-binary (2%), genderqueer (2%), trans/transgender (1%), gender-fluid (1%) and Two-spirit (<1%).

To understand the level of personal experience relative to substance use, respondents were asked to select statement(s) that best described their experience. Respondents could select more than one option (**Figure 6**). The majority selected working directly with people who use substances and/or people in recovery (69%), followed by having close friends or family members who use substances (61%) and working on policies, programs, or practices that directly serve people who use substances (54%). Less than half (45%) indicated they use or had used substances.
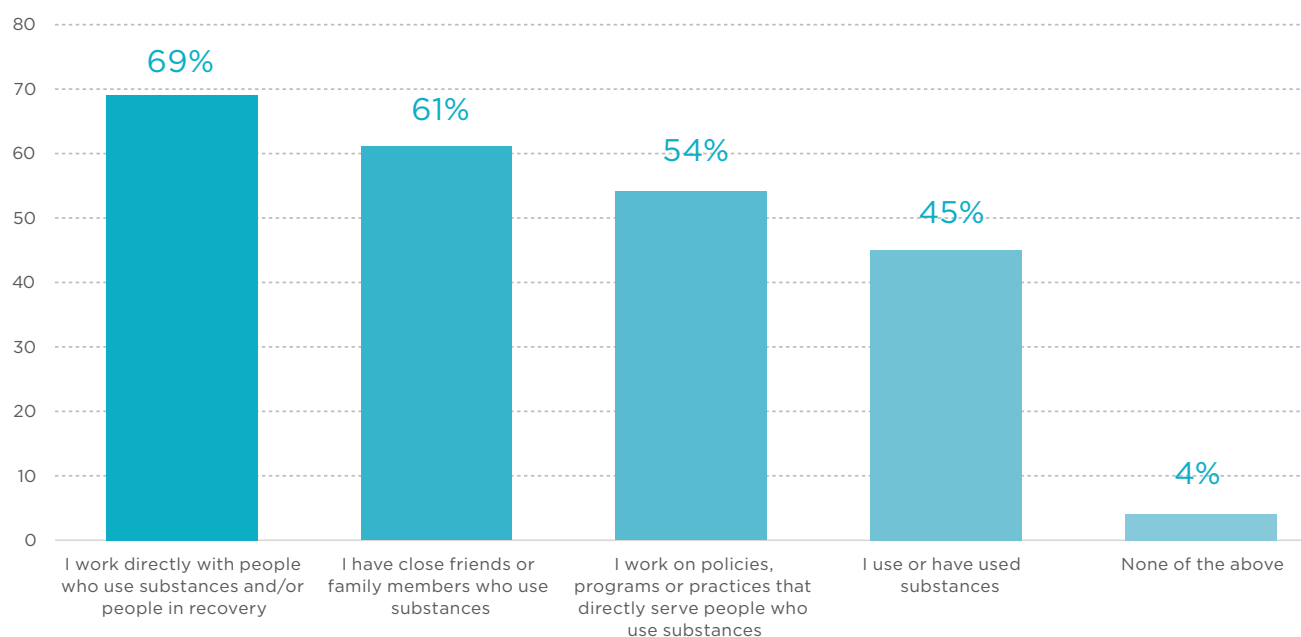
Figure 6: **Personal experiences related to substance use**

Information sources and knowledge about specific substances and available services

Respondents were given a list of options and could select all that applied regarding sources where they found information about substance use (**Figure 7**). The most popular sources included colleagues/other professionals in the same field (83%), harm reduction organizations (75%), people who use substances and/or personal experience of substance use (74%), organizations focused on substance use (73%) and academic journals (61%).

Source	Responses (%)
Colleagues/other professionals in my field	83%
Harm reduction organizations (e.g., supervised consumption sites, needle and syringe programs)	75%
People who use substances and/or personal lived experience of substance use	74%
Organizations focused on substance use (e.g., CCSA, CAMH, CISUR) - please specify	73%
Academic journals (e.g., accessed through Google Scholar)	61%
Government of Canada reports	55%
Provincial reports (e.g., government, agency)	52%
Local public health units	50%
Media outlets (e.g., CBC)	44%
Professional associations (e.g., CNA, CPHA) - please specify	43%
Community events	41%
Friends, family and social networks	37%
Indigenous governments & organizations	37%
Social media (e.g., Twitter, Facebook)	31%
Municipal or regional reports	30%
Police services (e.g., RCMP, provincial police service, municipal/local police service	24%
Other - please specify	5%

Responses (%)

Figure 7: **Information sources**

Respondents were asked to rate their general knowledge about the following substances or substance categories: alcohol, cannabis, nicotine, opioids, psychedelics, stimulants and sedatives (**Table 1**). Overall, "some knowledge" was selected by about half of the sample in relation to psychedelics (51%), sedatives (51%) and nicotine (50%). The only substance for which most respondents rated their knowledge as "advanced" was alcohol (63%).

	No knowledge	Very little knowledge	Some knowledge	Advanced knowledge	Unsure
Alcohol	0%	1%	36%	63%	0%
Cannabis	0%	5%	46%	48%	0%
Nicotine	1%	8%	50%	41%	0%
Opioids	1%	8%	44%	47%	0%
Psychedelics	4%	28%	51%	17%	0%
Stimulants	2%	14%	46%	37%	0%
Sedatives	2%	18%	51%	27%	0%

Table 1: **Self-rated knowledge of different substances**

Respondents were also asked an open-ended question regarding substance(s) for which they would like further education or information and 311 answered this question. Among the most mentioned substances were psychedelics, stimulants (crystal methamphetamine was often explicitly mentioned), sedatives/benzodiazepines, opioids, cannabis and alcohol. Many respondents noted they needed to learn more about a substance's specific uses or applications and/or impacts. For example, many who said "psychedelics" added they were interested in receiving more information about the therapeutic potential of these drugs, often in relation to mental health.

"Stimulants, specifically methamphetamines as use is increasing in our communities (and from anecdotal information from colleagues in other communities, they are seeing this trend also)". (Post-secondary institution)

"Psychedelics, cannabis and benzos. There has been some research that psychedelics are as effective at depression treatment as mainstream therapeutics. Let's learn more about this topic on a societal scale." (Government)

A number of respondents indicated they wanted more information about the combined use of multiple substances, especially related to how benzodiazepines interact with other sedatives and opioids. Some also stated they would like to learn more about "contaminants" and common substance combinations relevant to increasing the toxicity of unregulated drugs.

"Sedatives particularly as they relate to interaction with opioids as current street supply of opioids is often now tainted with benzos as filler." (Health care sector)

Many respondents who mentioned alcohol and cannabis noted a need to learn more about the impacts of legal regulation on the wide-ranging, often recreational or social, use of these substances.

"I am still waiting to see more emerging evidence regarding the impact of the legalization of cannabis, in terms of social impacts and if there will be an increase in cannabis related mental health concerns with youth who use cannabis. Anything that is "normalized" in society is often more likely to be used by youth. I worry about increased schizophrenia related to youth cannabis use." (Health care sector)

"More education on alcohol would be great! I think a lot of people underestimate the devastating effects of alcohol just because it is used for recreation so often." (Health care sector)

Regarding knowledge of substance use services, respondents were asked to select all options that applied from a list of programs and services that, to the best of their knowledge, were available in their local community (**Figure 8**).

Peer support groups (92%), substance use treatment and/or recovery programs, such as support groups and counselling (86%), opioid agonist treatment (84%) and smoking cessation services (84%) were selected most often. More specific types of harm reduction services were selected less frequently, such as supervised consumption sites (46%), overdose prevention sites (43%), drug checking services (36%) and safe supply (26%).
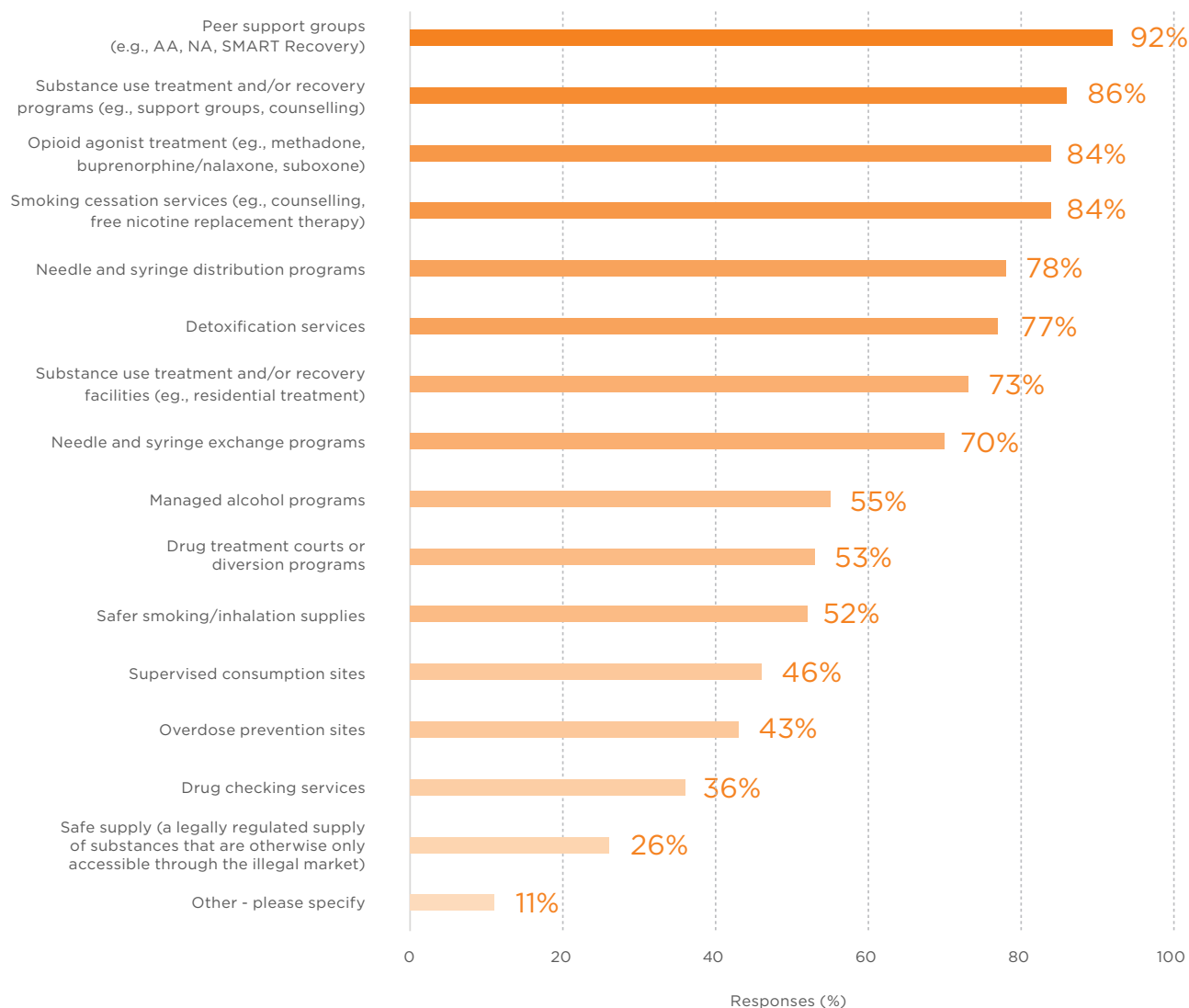
Figure 8: **Self-rated knowledge of different substances**

Respondents were also asked about their level of agreement with the following statement: "I would know where to refer someone if they were seeking programs or services related to substance use". Agreement with this statement (combining responses of "agree" and "strongly agree") was reported by 83% of the sample.

Perceived harms and benefits associated with substance use

Respondents were asked to rate the harms of the same substances or substance categories noted above (e.g., alcohol, cannabis, etc.). Specifically, respondents were asked to rate the harmful health and/or social impacts of each substance in their local communities (**Table 2**).

	No knowledge	Very little knowledge	Some knowledge	Advanced knowledge	Unsure
Alcohol	0%	2%	29%	68%	1%
Cannabis	5%	35%	46%	13%	2%
Nicotine	1%	8%	40%	46%	1%
Opioids	0%	2%	15%	82%	1%
Psychedelics	4%	29%	35%	19%	13%
Stimulants	0%	3%	26%	67%	4%
Sedatives	0%	7%	42%	40%	10%

Table 2: **Perceived harmful impacts**

The highest proportion of respondents indicated opioids had a "major harmful impact" (82%). Alcohol (68%) and stimulants (67%) also received considerable agreement as having major harmful impacts. While nearly 35% thought cannabis had "very little harmful impact", 46% indicated cannabis had "some harmful impact".

When asked to specify types of harmful impact, 237 respondents provided more detail. Commonly mentioned harms included, but were not limited to:

- Overdose and mortality due to overdose

- Chronic disease and various cancers (especially related to alcohol and nicotine)

- Emergency department visits

- Mental health concerns (e.g., psychosis, depression, anxiety)

- Addiction or dependence

- Cognitive and memory impairments

- Impaired driving

- Loss of work/unemployment

- Financial problems

- Family and relationship problems

- Stigma and discrimination

- Violence and trauma (especially increased likelihood of being a victim of violence)

- Encounters with the criminal justice system

- Litter and other environmental impacts (e.g., discarded needles)

Alcohol was mentioned frequently in respondents' open-ended answers as associated with numerous harms, including harms linked to acute intoxication (e.g., impaired driving) and longer-term health-related harms (e.g., chronic disease). Some respondents mentioned they thought not enough public health policy attention was given to alcohol despite its high burden on the healthcare and social service systems.

"The negative impact of alcohol on individuals, families and society cannot be overstated, yet progress and action remain weak at best and regressive in most accounts. It is time for public health to better mobilize on the commercial determinants [of] health and address alcohol and alcohol industry as a major public health and social justice concern." (Government/policy sectors)

I" personally believe alcohol use contributes to a lot of death, morbidity and social harms (domestic abuse, drunk driving). Nicotine is also a very expensive and harmful drug; in that it causes a lot of lung cancer. [...] Opioids obviously kill a lot of people." (Health care sector)

Numerous respondents highlighted the opioid fentanyl, noting its association with a higher risk of overdose and death due to overdose. Respondents from health care, public health and community-based harm reduction were likely to mention how they had observed increases in the incidence of overdoses due to opioid use and heightened toxicity in the unregulated drug supply, especially in relation to fentanyl.

"The use of fentanyl is life threatening and many overdoses resulting in death are more often than not related to fentanyl." (Public health sector)

"A fentanyl overdose was the cause of death for five people I knew personally within the last eight months. Crystal meth has caused people I know to lose their jobs and the place they called home, their health has drastically declined in a short period of time [and] some turn to more dangerous substances, i.e., fentanyl." (Health care sector)

Some respondents also stated they do not view substance use as inherently harmful, noting that criminalization, stigma and other social-structural conditions lead to more harms for communities.

"I would like to note that not all substance use is problematic and therefore not all substance use has a harmful impact. There are people who use alcohol, cannabis, cocaine, opiates etc. in ways that has very little harmful impact on their lives. It is much less about the substance and much more about pattern of use. Also, stigma [regarding] a substance can be more harmful than the substance use of itself – [like] criminalization." (Social services sector)

"The substances do not cause harm, the context in which people have to use their substances cause them to be harmful to themselves and our communities. Example [...] criminalization, racism (specific to who society 'allows' to use substances vs not), manufactured poverty, houseless/homelessness (visible use vs non-visible) and recognizing that substance use is a harm reduction strategy for some who are impacted by day-to-day colonial and structural violence." (Non-governmental organization)

Respondents were also asked to rate the same substances or substance categories in terms of any beneficial health and/or social impacts in their local communities (**Table 3**).

	No beneficial impact	Very little beneficial impact	Some beneficial impact	Major beneficial impact	Unsure
Alcohol	25%	39%	31%	2%	3%
Cannabis	10%	25%	53%	9%	2%
Nicotine	54%	28%	14%	1%	3%
Opioids	40%	24%	29%	4%	3%
Psychedelics	38%	24%	23%	6%	10%
Stimulants	54%	24%	13%	3%	6%
Sedatives	28%	30%	29%	3%	9%

Table 3: **Perceived beneficial impacts**

For each substance or substance category, ratings of "major beneficial impact" were endorsed by less than 10% of respondents. Over half of the respondents said nicotine (54%) and stimulants (54%) had "no beneficial impact". Compared to the other substances, cannabis (53%) received the most ratings of "some beneficial impact".

When asked to specify the types of beneficial impacts, 251 respondents added more detail. Commonly mentioned beneficial impacts included, but were not limited to:

- Pain relief

- Management and improvement of health/mental health concerns and symptoms (e.g., insomnia, anxiety, depression)

- Supporting general mental health and well-being

- Coping with experiences of trauma, violence and marginalization

- Supporting substance use treatment and/or withdrawal management

- Replacement or substitute substance use (e.g., use of cannabis instead of opioids)

- Social connections and social inclusion

- Pleasure, fun and recreation

- Employment and economic opportunities

Many respondents spoke about general benefits of substance use, recognizing that many people who use substances experience varied and multiple beneficial impacts. Commonly mentioned benefits included pain management and coping with other health-related issues, particularly mental health concerns.

"As a health care or service provider, most of the time we see the harmful [effects] of substances, even more if they are non-prescribed and illegal. From the substance users' perspective, substance use has benefits most of the time, otherwise they would not use substances." (Public health sector)

"Many people I know cope with their trauma by using substances, opioids, stimulants, etc. It's for this reason that I feel it has some beneficial impact because it allows people to move through the day and continue on with life, despite their mental health challenges." (Social services sector)

For some respondents, only prescribed or clinically monitored substance use was thought to be associated with beneficial impacts. In addition, some believed benefits only occur when substance use happens "in moderation".

"When prescribed properly some of the above substances can be helpful for people or used in a harm reduction approach." (Government sector)

"Drug use in moderation or under a lens of healthy substance use can have many therapeutic supports including managing pain, mental health and promoting connection." (Health care sector)

"Aside from prescription use, most of these substances have no benefit. Cannabis may have some positive benefits for some illnesses, but for most, the drug has few positive benefits in the long run." (Justice system)

Some respondents specified benefits by different types of substances. Oftentimes, opioids were discussed in the context of pain relief. Alcohol was often discussed relative to social activities and connections. Alcohol and cannabis, both legal substances in Canada, appeared more likely than other substances to be mentioned in relation to employment and economic opportunities. A smaller number of respondents explicitly mentioned that psychedelics had therapeutic potential, especially for mental health concerns.

"Cannabis: alternative to other more harmful substances; Opioids: when properly prescribed, pain reduction; Psychedelics: some beneficial impacts from breakthrough treatments for depression." (Social services sector)

"Alcohol: social integration when used in moderation; Cannabis: when used in moderation (ideally medically supervised/monitored) for pain and other symptoms; Opioids/benzos: when prescribed responsibly; Stimulants: when prescribed responsibly for ADHD, ADD etc.; Ketamine: for procedural sedation." (Health care sector)

Notably, within the context of beneficial impacts, a few respondents mentioned the ongoing need to address gaps in appropriate and accessible health and social services.

"I find this very difficult to answer for each particular substance, so on a more general level I think substances can be used as a coping mechanism to the person using them in order to mask trauma, pain, social anxiety, etc. However, I feel we are in need of more access to mental health/addiction supports and break down barriers and wait lists, increased prevention in schools and youth programming." (Public health sector)

"Many people living in poverty and precariousness do not have their realities acknowledged by mainstream social services. Because of this, many people are suffering through untreated trauma, PTSD. [...] Substance use is sometimes a way for people to tolerate intolerable conditions." (Social services sector)

Beliefs regarding why people use psychoactive substances

Respondents were asked why, in their view, people use psychoactive substances. A list of options connected to various core beliefs about substance use was provided and respondents could select all that apply (**Figure 9**). Several response options were selected by over 90% of respondents including "stress (e.g., physical, psychological, economic)", "response to trauma or violence", "social or recreational purposes", "pleasure" and "dependence/addiction".
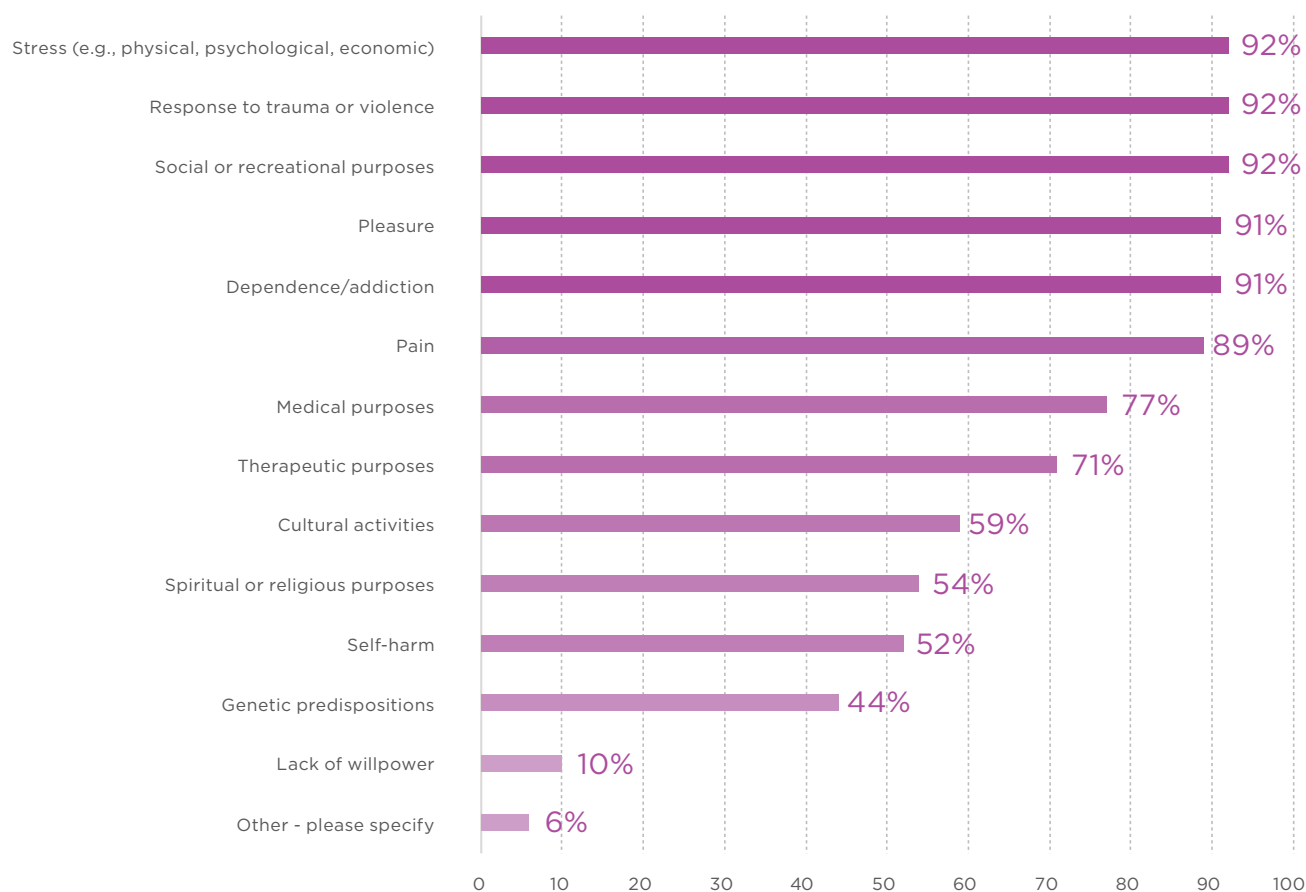
Figure 9: **Beliefs regarding substance use**

Almost 200 respondents provided an additional explanation, most focusing on the fact that there are "many" or "various" reasons why people use substances. Many noted that substance use is complex - a multitude of motivations are possible and individuals often have more than one. Numerous respondents also stated they believed that people use substances to cope with physical and/or emotional pain and/or as a response to trauma. However, some of these and others stated it is also important to recognize pleasure and fun as key reasons why people use substances.

"Substances can be used for a wide variety of reasons. Everyone's purposes for use is different."
(Public health sector)

"I think pain and trauma is the greatest reason for substance use. Also wanting to maintain social connection."
(Social services sector)

"Drugs are used for many coping strategies, but people often forget that drugs are also used for pleasure and fun."
(Government sector)

Some respondents highlighted that an individual's reasons for using substances can change over time and across circumstances. Several noted a distinction between initially trying substances and other phases of substance use.

"I think it is worth separating why someone "tries" psychoactive substances vs. why they continue to use. There are myriad reasons for people to try something for the first time – some of which may apply to why they continue to use, but not always." (Health care sector)

"Initially, people's substance use typically achieves a desired outcome. For example: they feel better, pain is relieved, anxiety is reduced, etc. Motivation behind someone's drug use may fluctuate over time. Some people are able to use substances without it ever becoming problematic or experiencing any adverse events related to their drug use. Others may experience both positive and negative outcomes from their drug use." (Public health sector)

Please note that some respondents wrote about their disagreement with the survey option: "lack of willpower". As noted in the Methodology section above, this option was included because it is a commonly used phrase regarding beliefs about substance use. Those who disagreed stated they do not believe that lack of willpower is a credible reason behind substance use and found that language stigmatizing. A few also mentioned "self-harm" also connects to misunderstandings and stereotypes about substance use.

"I selected everything except for 'lack of willpower' because I personally don't feel that is a reason people use." (Public health sector)

"The only reason I disagree with is lack of willpower. I want to clarify though that sometimes people use substances for self-harm [and] this motivation is generally misunderstood and over applied. But most substance use is not self-harm, this is a stereotype." (Justice system)

Notably, 10% of respondents selected lack of willpower among their beliefs regarding why people use psychoactive substances.

Impacts of stigma and other beliefs

Citing the Canadian Centre on Substance Use and Addiction (2019), stigma was defined in the survey as follows:

> *Stigma can be broadly understood as any attitude, belief, or behaviour that discriminates against people. Many people encounter stigma in their daily lives and we can amplify or extend the effects of stigma without meaning to.*

A majority of respondents (67%) rated their knowledge of how stigma affects people who use substances as "high", a considerably greater proportion than those who rated their knowledge as "intermediate" (29%), low (3%), or unsure (1%).

Respondents were asked other questions related to stigma and beliefs about substance use. Specifically, about their level of agreement with the following statement: "I have witnessed misperceptions or misunderstandings about substance use leading to preventable health and social harms". Agreement with this statement ("agree" and "strongly agree") was reported by 84% of the sample. Only 2% disagreed with the statement, while 8% neither agreed nor disagreed.

Respondents were also asked about their level of agreement with the following statement: "I believe people should accept responsibility for the impact their substance use has on friends and family". Interestingly, while 52% of the sample agreed or strongly agreed with this statement, 33% neither agreed nor disagreed and 11% disagreed or strongly disagreed.

Additionally, respondents were asked about their level of agreement with statements regarding their comfort discussing substance use. Although a number of different and intersecting factors (e.g., personal knowledge and relationships with others) could affect agreement with such statements, stigma and/or beliefs about substance use can also play a role. One question asked whether respondents agreed with the following statement: "I am comfortable talking about substance use with my clients or people I engage with as part of my work". Agreement or strong agreement with this statement was reported by 89% of the sample, while 6% neither agreed nor disagreed and only 3% disagreed or strongly disagreed. Another question asked about agreement with a similar statement: "I am comfortable talking about substance use with colleagues and/or other professionals in my field". In this case, 92% agreed or strongly agreed.

Different approaches to substance use

Respondents were asked to rate their knowledge about the following four broad approaches to substance use: criminal justice/enforcement, harm reduction, prevention and treatment (**Table 4**).

	Not aware	Low	Intermediate	Advanced	Unsure
Criminal justice/ Enforcement	1%	20%	50%	28%	1%
Harm reduction	1%	6%	34%	59%	0%
Prevention	0%	11%	49%	39%	1%
Treatment	1%	17%	45%	37%	0%

Table 4: **Self-rated knowledge of different approaches to substance use**

Only harm reduction received ratings of "advanced" knowledge from a majority of respondents (59%). Approximately half of the sample rated their knowledge as "intermediate" for criminal justice/enforcement (50%) and prevention (49%).

Respondents were also asked about specific legal and policy frameworks for approaches they believe are best for reducing health and social harms related to substance use for individuals and communities. For this question, respondents could select more than one option (**Figure 10**).
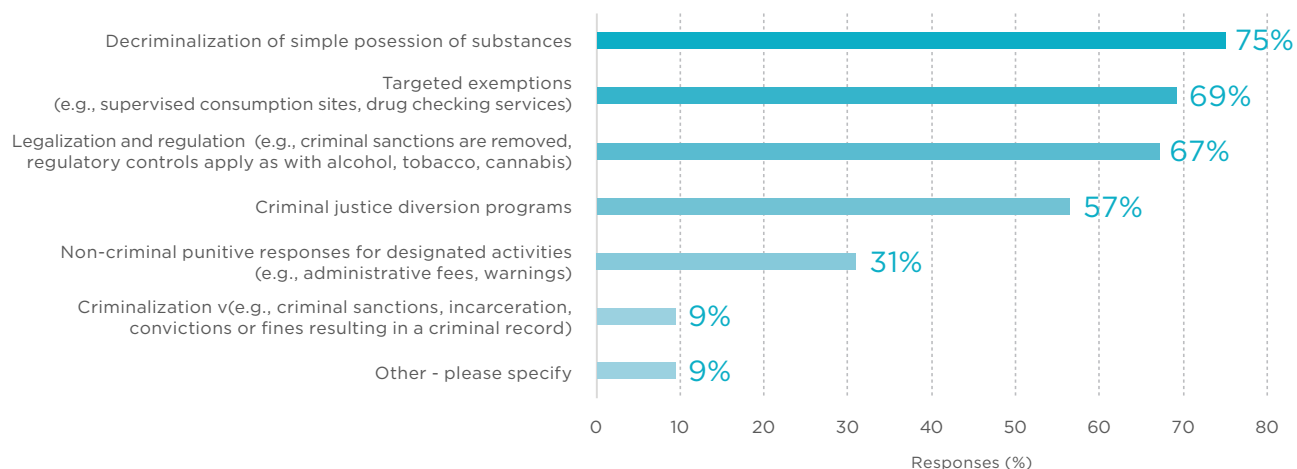
Figure 10: **Endorsement of legal and policy frameworks as best for reducing individual and community harms associated with substance use**
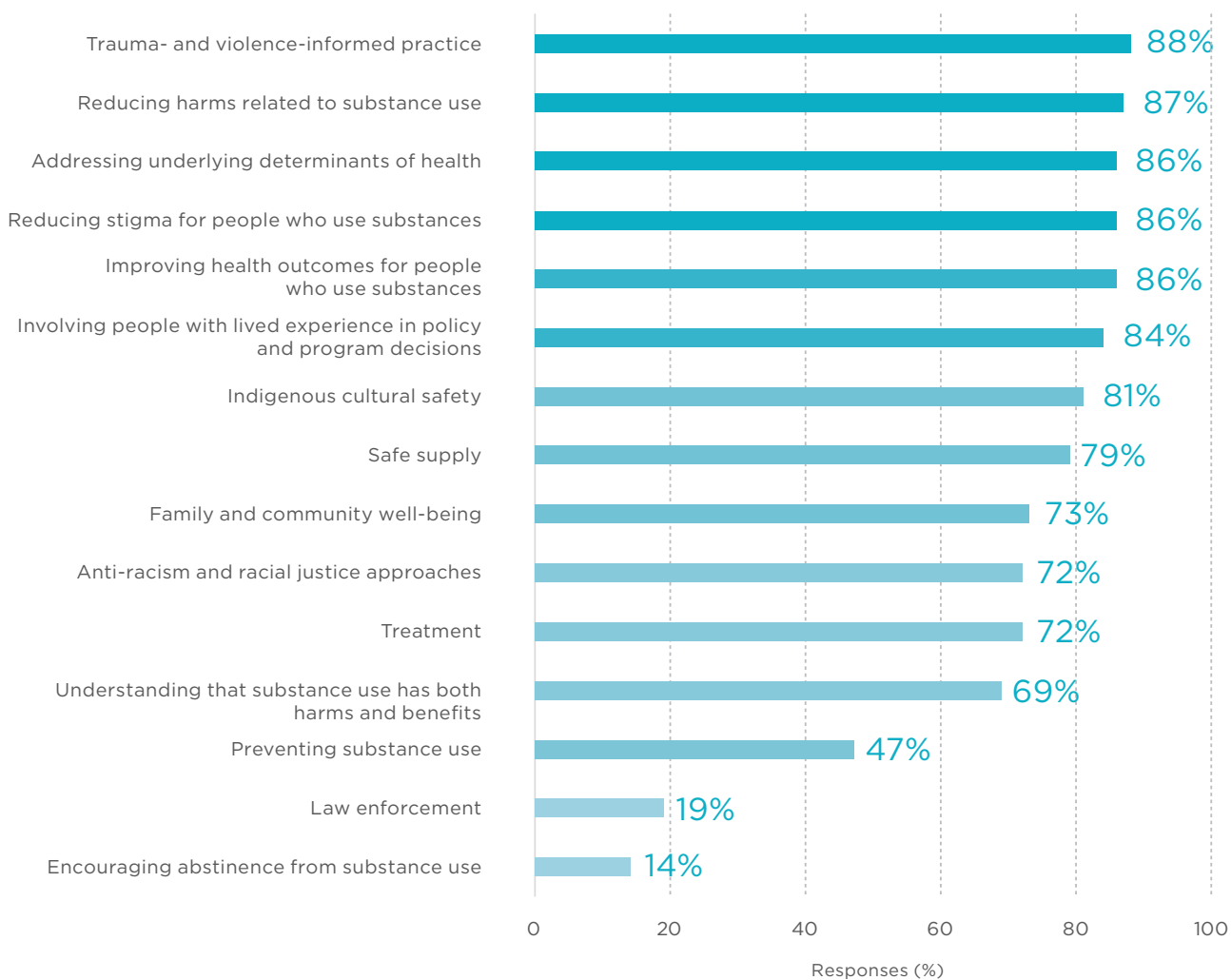
Regarding the best legal and policy frameworks to reduce individual and community harms associated with substance use, most respondents selected decriminalization of simple possession of substances (75%), targeted exemptions (69%), legalization and regulation (67%) and criminal justice diversion programs (57%). Targeted exemptions were further defined in the survey as legal exemptions via programs such as supervised consumption sites and drug checking services.

Only 9% of the sample selected criminalization as the best approach to reduce health and social harms related to substance use. A further 9% selected "other" and many of these respondents specified general approaches such as harm reduction and stigma reduction as necessary for reducing harms associated with substance use.

An additional question listed specific principles and practices, some of which underlie general approaches to substance use such as harm reduction and criminal justice. Respondents were asked to rate each in terms of its importance, or lack of importance, regarding how to approach substance use. **Figure 11** shows the percentage of the sample who endorsed each option as "important" or "most important". Respondents could rate multiple principles and practices as important.

CANADIAN
PUBLIC HEALTH
ASSOCIATION

ASSOCIATION
CANADIENNE DE
SANTÉ PUBLIQUE

Principle/Practice	Responses (%)
Trauma- and violence-informed practice	88%
Reducing harms related to substance use	87%
Addressing underlying determinants of health	86%
Reducing stigma for people who use substances	86%
Improving health outcomes for people who use substances	86%
Involving people with lived experience in policy and program decisions	84%
Indigenous cultural safety	81%
Safe supply	79%
Family and community well-being	73%
Anti-racism and racial justice approaches	72%
Treatment	72%
Understanding that substance use has both harms and benefits	69%
Preventing substance use	47%
Law enforcement	19%
Encouraging abstinence from substance use	14%

Responses (%)

Figure 11: **Perceived importance of different principles and practices**

Over 80% of the sample selected the following as important principles and practices: trauma- and violence-informed practice (TVIP); reducing harms related to substance use; addressing underlying determinants of health; reducing stigma for people who use substances; improving health outcomes for people who use substances; involving people with lived experience in policy and program decisions; and Indigenous cultural safety. Notably, 47% of respondents selected preventing substance use and 14% selected encouraging abstinence from substance use as important, reflecting perspectives that may prioritize avoidance of substance use.

Understanding of harm reduction

In keeping with the scope of the larger project, the survey also included a set of questions designed to unpack understanding of harm reduction and TVIP.

Overall, 711 respondents answered an open-ended question asking how they would define a harm reduction approach to substance use. Most commonly, respondents described harm reduction as an approach focused on reducing the health, social and economic consequences associated with substance use. Many also explicitly noted a harm reduction approach does not require abstinence from substance use.

Frequently, respondents stated that harm reduction should be about "meeting people where they are at". This specific phrase, or variations of it, appeared often and was provided by different sectors. Numerous respondents explained harm reduction in practice means offering a range of safer use and/or service options to people who use substances. Further, many emphasized the importance of applying "person-centered" or "person first" principles in harm reduction practice (e.g., approaching service users without judgment or stigma and showing empathy and respect).

"A harm reduction approach to substance use […] is working with the person to prioritize their self-identified risks and then working with them to develop strategies to reduce their identified risks. It is about having open and honest conversations [about] their substance use including what benefits they are getting from their substance use as well as risks. It is about looking past the person's substance use to see the whole person and to foster caring, compassionate, empathic and supportive relationships." (Health care sector)

"Harm reduction […] is radically accepting and non-judgmental. It is a wraparound approach that provides access to materials and services that reduce the likelihood of harm and increase the quality of life of a person who uses substances. It is intended to meet a person where they're at and not impose a stigmatized or criminalized approach to supports." (Non-governmental organization)

A wide array of examples of harm reduction were provided. Most examples were specific types of substance use-related programs or interventions including, but not limited to, the following:

- Detoxification services
- Drug checking/testing services
- Managed alcohol programs
- Needle/syringe exchange and distribution programs
- Opioid agonist treatment (e.g., methadone, buprenorphine)
- Overdose prevention sites
- Peer support groups and outreach

- Safe supply programs (e.g., prescribed medications as alternatives to illegal drugs)
- Safer alcohol and/or drug use education or guidelines (e.g., guidance on not using drugs alone, starting "low and slow")
- Sharps container distribution for safer disposal of drug use equipment
- Supervised consumption sites (including injection and/or inhalation sites)
- Take-home naloxone kit distribution

Specific types of individual and group counselling and treatment services were mentioned but not as commonly as the examples above. When detoxification services and substance use treatment were mentioned, respondents often suggested these programs should be more accessible (i.e., free or not cost-prohibitive) and widely available as options for people who are ready to access such supports.

Some respondents also provided examples of other types of harm reduction as highly relevant to support their definitions of the approach, while noting these as other key supports for people who use substances. These types of examples included distribution of safer sex and birth control supplies, accessible and affordable housing, stigma reduction campaigns and guidelines and other health and wellness programs, especially community-based "wraparound services".

A sizable number of respondents explicitly mentioned trauma-informed approaches (see next section) in their definition of harm reduction. Although less common, a notable proportion of respondents also discussed broad drug policy reform – namely, shifts away from prohibition, such as decriminalization initiatives and legalization – as a critical component of harm reduction. Relatively few respondents discussed harm reduction as encompassing "social justice" and use of decolonizing, anti-racist, queer and/or feminist lenses in practice. That said, many respondents suggested harm reduction efforts are generally meant to increase the visibility, inclusivity and leadership of people who use substances, noting this population is highly diverse.

"Harm reduction needs to be built on 'healing-centred harm reduction' and ultimately rooted in anti-racism, be anti-colonial, anti-capitalist, abolition and decriminalizing of ALL substances." (Social services sector)

"Harm reduction is by the people, for the people, and requires meaningful inclusion and prioritization of people with lived and living experience of drug use." (Health care/non-governmental organization sectors)

Understandings of trauma- and violence-informed practice (TVIP)

The survey adopted a simplified version of the definition of TVIP proposed by the Centre of Excellence for Women's Health (Schmidt et al., 2019):

Trauma- and violence-informed practice can be broadly understood as the establishment of settings where people do not experience further traumatization or re-traumatization.

Respondents were asked how they would rate their level of knowledge of TVIP (**Figure 12**) and whether they see a role for TVIP in work that involves or impacts people who use substances. A somewhat higher proportion of respondents perceived their knowledge of TVIP as "intermediate" (46%) compared to those who rated their knowledge as "advanced" (36%).
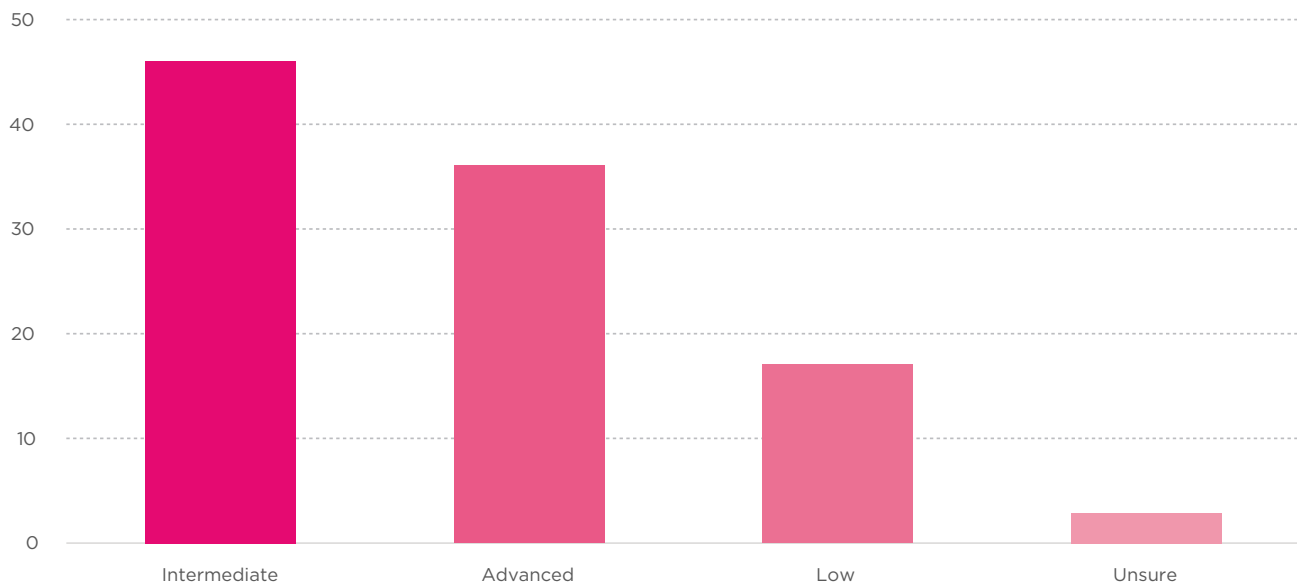
Figure 12: **Knowledge of TVIP**

A large majority of respondents (93%) indicated they saw a role for TVIP in their work that involves or impacts people who use substances. When asked to explain their answers regarding a role for TVIP, 480 respondents answered, particularly those who rated their knowledge of TVIP as intermediate or advanced. Respondents most often mentioned they know of and/or saw in their work a very high proportion of people who use substances and who have personal histories with trauma and violence (often further specified as people living with experience of addiction or other problems directly related to their substance use). As such, many respondents thought TVIP is an integral or inseparable part of substance use services and care. Many also noted experiences of social exclusion and discrimination are intertwined with trauma and violence, and people from structurally marginalized communities have been disproportionately impacted by these experiences.

"There are a variety of reasons an individual uses substances: [...] a means to cope with stress, trauma, or other distress, to keep safe (staying up while sleeping on the streets), as a learned behaviour from family, peers or society, as a result of colonization, capitalism and other forms of oppression, etc. Because of this, it is critical that individuals accessing substance use supports not be re-traumatized when accessing services." (Health care/non-governmental organization sectors)

"Many people who use substances have experienced a high level of trauma throughout their lives, including social exclusion, discrimination, intergenerational trauma through the residential school system, systemic racism, sexual violence, neglect and physical and emotional abuse [...]. Trauma- informed care is critically important when treating people with substance use issues, because if they feel marginalized by their care providers, or abused in any way, it breaks their trust and they may not accept harm reduction services when offered." (Health care sector)

"We have grossly underestimated the connection between trauma and problematic substance use. We have also underestimated the impact of being arrested and incarcerated over and over again. I think there is not only a role, but trauma- and violence-informed approaches should be foundational. It leads to understanding and a change in perspective when we see someone and their actions through a trauma-informed lens." (Justice system)

Respondents often made connections between TVIP and increasing quality of care, noting that TVIP provides a lens to see an entire person and foster conversations that feel safer for service users and sensitive to individual needs. Similarly, many respondents stated TVIP requires language that conveys compassion and active listening, also noting many people who use substances have had health care system experiences that lacked compassion and/or involved stigma and discrimination from service providers.

"[TVIP] allows a shift from a place of 'what is wrong with you" to "what happened to you". [It] allows the clinician to focus on the person and their needs, their traumas, their experience in their life and not on moral judgment and stigma." (Health care sector)

"Too often we have individuals who think they know what is best for individuals without asking them, this just causes more pain and trauma. Language is important, attitude is important, compassion is important, listening is important, respect is important." (Health care sector)

"People won't wish to engage with any formal systems of care that are not treating them as whole people with intersecting events and experiences that have contributed to their substance use at that point. If programs and services are trauma- and violence-informed, the people accessing them will likely have better outcomes because they will be able to start where they need to start and see themselves as whole persons with needs beyond just getting clean." (Government)

Of those who provided detail about the role they see for TVIP and who appeared strongly in favour of this approach as essential to support people who use substances, many also noted a need for greater education and training on and implementation of TVIP in practice.

"Structural violence perpetuates the stigma and discrimination of people who use substances […] Education on trauma- and violence-informed practice should be built into all professions who work with people who use substances, to be able to properly apply a harm reduction lens to work and better understand the complex histories and needs of this population." (Health care sector)

Respondents often mentioned that the need for professional education and training on TVIP exists across sectors and professions.

Familiarity and comfort with a public health approach to substance use

The survey included a section that contained questions critical to the objectives of the larger project, specifically, regarding a working definition of a "public health approach to substance use" and how such an approach is defined and implemented. These questions were based on the definition of a public health approach noted earlier in the report: a non-judgmental approach that seeks to maintain and improve the health of populations based on principles of social justice, attention to human rights and equity, evidence-informed policy and practice and addressing the underlying determinants of health.

Respondents were asked if they had heard of this kind of approach to substance use and a majority (76%) said yes (**Figure 13**).
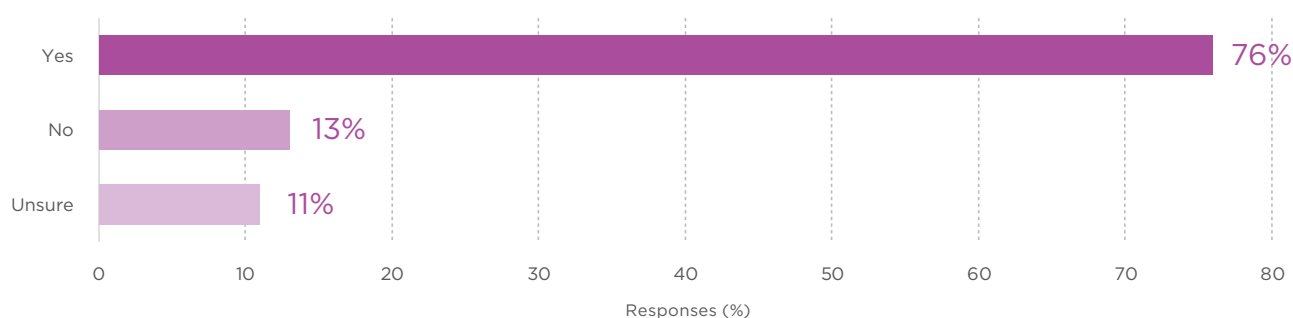
Figure 13: **Ever heard of a public health approach to substance use**

Next, respondents were asked about their level of comfort applying a public health approach to substance use, as defined in the survey (**Figure 14**). Over half of the sample (54%) indicated a high level of comfort applying this type of approach within the context of their work.
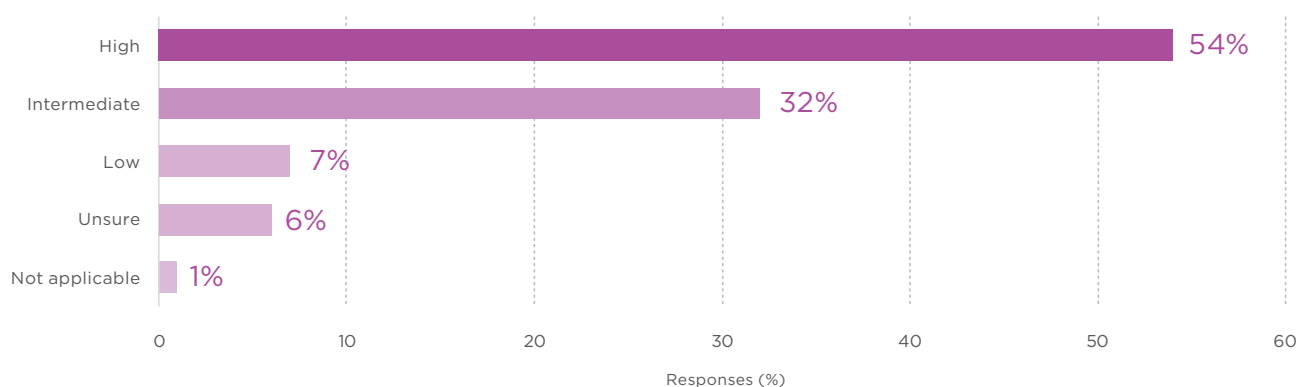
Figure 14: **Comfort with applying a public health approach to substance use**

When asked to define their level of comfort applying a public health approach to substance use, respondents who indicated a high level of comfort often noted their current and/or previous work experience. Some of these respondents shared that they have worked in their field (most often public health or health care) for a decade or longer. Many who indicated a high level of comfort also said they already applied a public health approach in their day-to-day work and that approach aligned with their personal beliefs and values. Many also shared their belief that a public health approach is the most effective approach to address substance use.

While many respondents who indicated a high degree of comfort worked in a health- or social service-related sector, some were from government and public safety sectors. In addition, many respondents who expressed a high level of comfort said a public health approach to substance use also aligned with their organizational or program mandates and goals.

"I have worked extensively with people with lived experience as a [...] clinician for over 10 years and also worked as public health promoter and substance use lead." (Public health sector)

"In my experience substance use is a public health issue. I am in law enforcement and have repeatedly seen firsthand how potentially harmful a criminalization and enforcement approach is." (Public safety sector)

"My organization and myself work from an anti-oppression lens where inclusion is prioritized overall. This means listening and meaningfully including people who use drugs to any health approach."
(Health care/non-governmental organization sectors)

Respondents who indicated an intermediate level of comfort applying a public health approach to substance use in their work noted concerns and observations about lack of support for such an approach among their colleagues, organization and/or agency partners. These respondents (particularly those in the government sector) noted the challenge of having conversations about a public health approach to substance use in the face of organizational resistance to adopting this kind of approach or, more generally, toward harm reduction practices.

"While I believe this is likely the framework to use going forward, governments are not there yet."
(Government/private sectors)

In addition, respondents with an intermediate level of comfort often shared a desire to learn more about a public health approach to substance use and ways it can be implemented, including opportunities to learn more about the relevant evidence base and develop applicable or practical skills. In other words, these respondents expressed their motivation by their desire for greater knowledge (as well as individual and organizational capacity and support) so they could apply a public health approach to substance use to their work.

"I am very comfortable with the approach but have limited ability to affect the social determinants of health or to implement a broad range of strategies due to the nature of the setting." (Justice system)

"I have some level of comfort with the public health approach, but I'd like to learn more and see the evidence of how it's been used in other places/countries around the world and what have been some of the different ways implementation have happened and some of the pros/cons to this approach and the key learnings." (Health care sector)

A minority (7%) of survey respondents said they had a low level of comfort applying a public health approach to substance use to their work. These respondents typically noted they either do not directly respond to substance use in their work or they lacked specific training on a public health approach (as defined) and its implementation.

Implementation of and barriers to a public health approach to substance use

Respondents were asked how likely it is that their organization would implement a public health approach to substance use. Considerable proportions of the sample indicated "very likely" (42%) and "somewhat likely" (30%); few indicated "somewhat unlikely" (7%) or "very unlikely" (6%). Respondents were asked to explain their answers regarding organizational likelihood to implement a public health approach to substance use. Most of the 236 respondents who provided further explanation perceived their organization as "very likely" or "somewhat likely" to implement such an approach.

Among respondents who answered, "very likely", the most common response was that their organization already uses this type of framework and/or is in the process of increasing their implementation of a public health approach to substance use via new services and policies that align with such an approach. Many of these respondents added, for example, that they work for a public health organization. Many also said their work embraces or directly entails harm reduction and mentioned relevant services they offer. In some cases, they explicitly noted their organization supports and advocates for the principles outlined in the survey's definition of a public health approach to substance use, such as evidence-informed policy, human rights and equity.

"I work for a progressive agency that seeks to empower its members to lead healthy lives through peer support and education." (Health care sector)

"I work for an organization that conducts research into substance use – we are fully on board with a public health, evidence-informed approach – we do not view criminalization as a viable solution." (Non-governmental organization)

"My organization actively engages for advocacy and social rights of Indigenous people who use substances." (Government/health care sectors)

Many respondents who answered "somewhat likely" discussed key barriers to implementing a public health approach to substance use. Some of these respondents came from public safety sectors, noting a need to balance competing goals and resources in their work to implement a public health framework.

The most common barriers to implementing a public health approach noted by respondents included resistance or a lack of organizational support from local and provincial governments and not enough funding to support fulsome public health strategies.

> *"The police – especially police services in large metropolitan areas – are supportive of public health approaches to substance use/abuse, but they have to balance that need with the need for public order and community safety. It is a bit of a balancing act, but preventative measures are always preferred to punitive ones."* (Justice system)
>
> *"My organization would be more likely if it was not funded by a government antagonistic to harm reduction and a [public health] approach to substance use."* (Health care/public health sectors)

Furthermore, many respondents who said "somewhat likely" noted that actual implementation of a public health approach to substance use is often inadequate in key areas such as cultural sensitivity, equity and stigma reduction. Several respondents mentioned a lack of policy prioritization for people who use substances, especially people from structurally marginalized communities.

> *"We are not always 100% there – as there are still levels of stigma and resulting discrimination, depending on where you are in the organization. There is still a sense of a pecking order, where people who use substances and engage in crime and are poor or racialized/Indigenous are at the bottom of the rung. This is especially true for those who use stimulants because there is the sense that there is 'nothing we can medically do for them.'"* (Justice system)
>
> *"I would like to believe a public health unit would implement this approach, but the pandemic has taught me just how low on the priority list People Who Use Drugs are, despite the fact we are in the midst of an equally dire opioid overdose crisis. They can talk about "priority populations" and "health equity" all they want but their actions do not indicate that these are actually a priority."* (Public health sector)

While a relatively small proportion of respondents indicated their organization was "very unlikely" to implement a public health approach to substance use, the few who provided more detail overwhelmingly noted a lack of organizational and governmental support and/or resources for said implementation.

> *"I work in the criminal justice system. Although individual professionals within the organization try to work constructively with inmates and parolees who misuse substances, the wider system takes a largely punitive and unsupportive approach. There are not enough resources, and the will is not there."* (Justice system)
>
> *"It is a 'dry' organization that doesn't actually support harm reduction. Although harm reduction is very intertwined with most services, there are aspects that can be seen in our programs."* (Social services sector)

Respondents were also explicitly asked about existing barriers, in their organization or community, to implementing a public health approach to substance use. A list of options was provided and respondents could select all that apply (**Figure 15**).
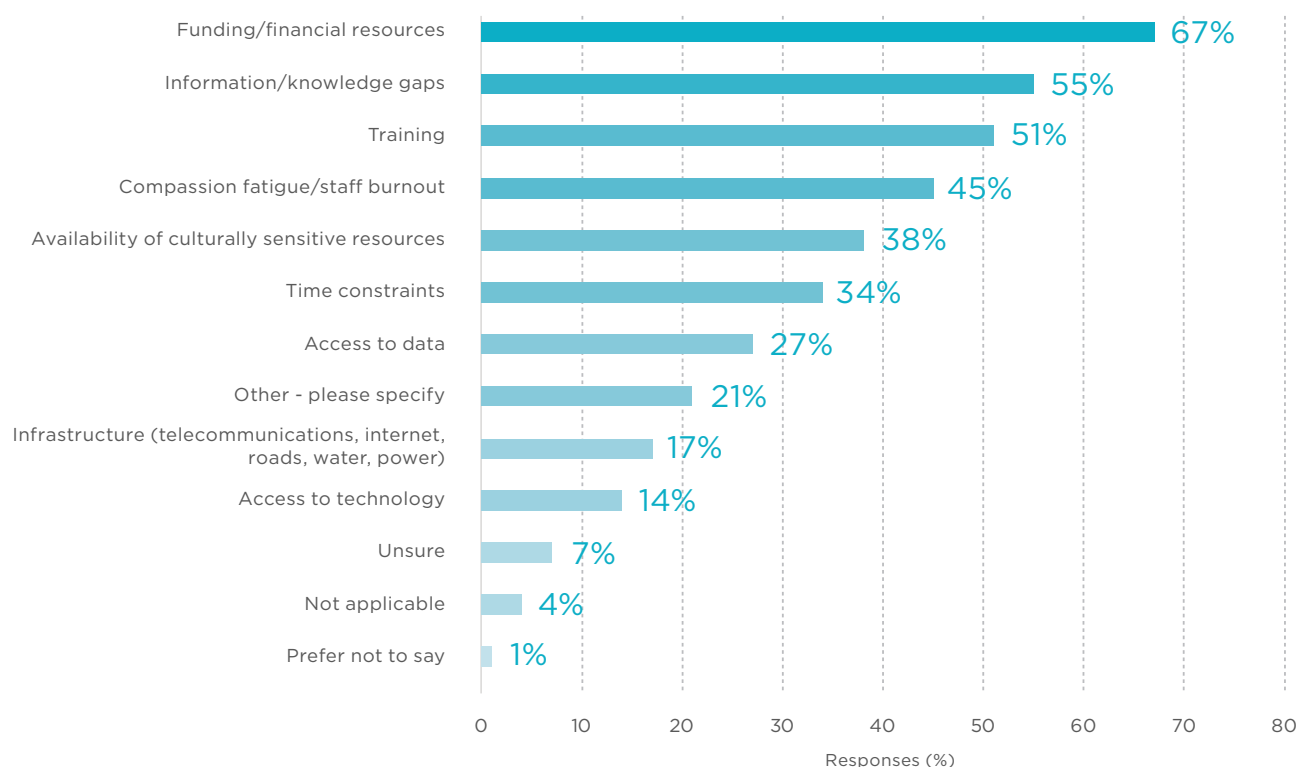
Figure 15: **Barriers to implementing a public health approach to substance use**

Most respondents agreed the following issues present barriers to implementation: funding/financial resources (67%), information/knowledge gaps (55%) and training (51%). Close to half of the sample (45%) also selected compassion fatigue/staff burnout.

Some respondents who selected "other" specified additional barriers not included in the survey response options. Stigma was commonly mentioned here. General or public stigma in relation to substance use was noted, as well as stigma from health and social service providers, politicians and governments. Numerous respondents also mentioned a lack of political will and/or public interest as other barriers to implementing a public health approach to substance use.

Suggested changes to the definition of a public health approach

Respondents were asked if there was anything they would add to or change about the survey's definition of a public health approach to substance use. Although some respondents indicated the definition was acceptable or thought no changes were needed, many provided suggestions for improving the definition. Areas for improvement centered on the following themes:

Greater inclusion of people with lived and living experience of substance use

Many respondents emphasized a public health approach to substance use must be informed and led by people with lived and living experience. This involvement is key at every stage, from developing principles of the approach to practical implementation. In these responses, people with lived and living experience were recognized as experts on the most needed programs and policies that would benefit them and their communities.

"I would like to see inclusion added to this definition. Something that speaks to the importance of including the validity of people with lived/living experience and expertise." (Public health sector)

"[The definition] does not include people who use drugs as the driver of a public health approach and situates public health within institutions and not within community. "(Non-governmental organization)

Incorporate trauma-informed approaches and compassion

Numerous respondents mentioned the survey definition of a public health approach needed explicit recognition of a trauma-informed lens. In connection with this suggestion, respondents also suggested the definition should state the importance of treating people who use substances compassionately, noting there are many social, personal and intersecting factors that influence substance use.

"[I]nclude 'trauma-informed' as trauma is so often an underlying cause and contributor to substance use. It is still not integrated into many addiction programs." (Social services sector)

Decolonizing and anti-racist approaches

Some respondents indicated that current policies, programs and approaches to substance use were based on colonizing structures and systemic racism. They often added that these structures had not only failed to effectively address substance use, but that Indigenous and racialized communities are leading the way in developing more holistic, safer and culturally sensitive approaches. Several respondents suggested the definition needed to underscore the importance of maintaining and improving the health of all populations, with inclusion and empowerment of groups that have been disproportionately impacted by existing substance use policies and approaches.

"Should be a holistic approach. […] First Nations are leaning now to conduct land-based treatment with a spiritual component of ceremonies [… and are] currently making an awareness program utilizing conventional and traditional teachings with a land-based treatment component that embraces ceremony and after care."
(Health care/social services sectors)

"Because this is a Canadian organization, I think it would be important to add something about challenging colonial structures". (Public health sector)

"[The definition] absolutely needs to recognize the impacts of white supremacy, capitalism and settler-colonial violence that states/institutions have on people who use drugs. Substance use-related harms are a SYSTEMS FAILING." (Non-governmental organization)

Different approaches and terms

Some respondents expressed diverse concerns with the wording and/or terminology used in the survey's definition of a public health approach to substance use. A few were concerned about the potential for continued stigma and marginalization of substance use implied by this definition. Instead of "public health", these respondents thought "human rights" or "ethics" might better capture the type of approach outlined in the survey, especially to describe an approach that respects individual autonomy and choice around substance use.

"I worry about a public health approach shaming drug use, as it has cigarette smoking, to push people toward abstinence. I think it is a human right to have bodily autonomy and that includes having the freedom to decide what goes into your body." (Social services sector)

Other respondents thought the definition missed or overlooked treatment and approaches to substance use that might not be considered related to public health or that did not align with harm reduction programs. For these respondents, a more inclusive definition meant more explicit acknowledgement of the significant individual and community harms that can result from substance use.

"[I]mplementation needs to embrace and value the role of treatment. Harm reduction strategies alone tend to ghettoize people in a 'safer user' category, with no exit strategy supported, made available, or expected of the health care system. It implies dismissal, a lack of deeper care and concern and unwillingness to be a link in a recovery-oriented system of care. This reinforces an ideological divide with a fatal gap. We need and must do better." (Health care/post-secondary institution sectors)

Lastly, some respondents suggested the definition needed greater clarity in its terms, including its interpretation of the "determinants of health" and "evidence-informed". A few respondents also raised concerns specifically about the term "social justice". These respondents thought this term had become politically loaded and polarizing, and its use impeded meaningful discussion about substance use.

"I am not going tell the Canadian Public Health Association how they should write the definition. All I request is to make the language softer, easy to read and comprehend. And if you refer to the Determinants of Health, take a couple to use as examples and clearly articulate what they mean."
(Public health sector, specified community-based needle distribution)

"The term 'social justice' does not tend to be well-received by key community partners, including police services, who are essential in providing coordinated community public health responses related to substance use."
(Government)

Training and resource needs

Over 300 respondents provided answers when asked about other topics for which they would like to receive more training or resources. Consistent with the themes reported above, many respondents mentioned they would like to have additional and/or updated resources on TVIP, stigma reduction and harm reduction. Several respondents said TVIP and stigma reduction training is centrally important for addictions counsellors and/or in their direct work with service users, especially to ensure non-judgmental and respectful service delivery. Related to harm reduction, safe supply was mentioned often as a type of intervention that people are eager to learn more about, including evidence of safe supply effectiveness.

Desires for training and resources about cultural safety, i.e., Indigenous cultural safety and anti-racism approaches, were also frequently mentioned.

"Trauma, multigenerational trauma, Indigenous health – more resources need to be used and available. "(Health care sector)

"Cultural safety for people who use drugs, Indigenous / BIPOC folks, women, LGBTQ2S." (Non-governmental organization)

"Trauma- and violence-informed practices, as it is one of the most common topics to come up in counselling." (Social services sector)

"Indigenous and racial justice approaches in substance use. Reminder information on determinants of health and how they can affect one's well-being/substance use. Trauma-informed practice." (Government)

While relatively few respondents provided details about how the highlighted resource topics might be integrated into their practice, those who shared such details mentioned professionals need greater education on anti-oppression and decolonizing strategies. These strategies were regarded as essential for training designed to help services better address the underlying social determinants of health that strongly influence substance use.

Finally, a number of respondents alluded to burnout as common in their professional field and/or asked for resources on how to manage navigating the day-to-day and systemic stressors in their work.

"Surviving working in this field." (Public health sector)

"How to work in harm reduction, long term-sustainability vs. burnout." (Public health sector)

"What I would like to see is working groups, collaboration and change to take place at a systemic level. What we are doing isn't working and the constraints imposed upon us by funders, contracted mandates and the constant 'hot potato' attitude of government agencies [...] makes it impossible to just simply help people. I have a wealth of skill and knowledge and I am getting ready to walk because it feels like it's an uphill battle that isn't going anywhere anymore." (Justice system)

Similar to the last quote above, other respondents noted key needs for broad systems change and recommended much more work and stakeholder buy-in for reform, beyond training and resource development, to implement a public health approach to substance use.

Discussion

CPHA's national survey of public health, public safety and other health and social service professionals has generated new information about these stakeholders' knowledge, beliefs and perceptions about substance use and relevant services, approaches and training. The survey was unique in that it included numerous open-ended questions and other prompts that captured a broader understanding of a public health approach to substance use and capacity to implement this approach.

The survey findings are timely as many policies, programs, and academic literature have called for a public health approach to reduce the harms associated with substance use. However, this approach is sometimes defined in contradictory ways or not clearly defined at all. In their recent qualitative systematic review and synthesis of literature Crépault et al., 2023 reported that, despite the lack of consensus about a public health approach to substance use in general, there is considerable agreement in the discussion of specific substances or classes of substances. For example, "regulation" is a commonly included feature of a public health approach vis a vis alcohol and cannabis, while "treatment" is a common feature of this approach for opioids (Crépault et al., 2023).

CPHA's survey results complement these trends. Of this national sample, 76% of respondents reported having heard of a public health approach to substance use and many provided nuanced understandings of such an approach in their open-ended answers. However, the survey also revealed varied and competing views about the key elements of a public health approach.

The survey data also uncovered a wide range of self-rated knowledge about specific substances/substance categories (e.g., alcohol, cannabis, nicotine, opioids, psychedelics), plus many different perceptions about the harmful and beneficial impacts of substances among varied professionals and practitioners across Canada. In future work, it will be valuable to examine in greater detail the survey data that illustrate what respondents say about a public health approach in relation to specific substances. Additionally, it will be important to explore professionals' perceptions about how divergent principles and practices fit within a public health approach to substance use. For instance, 14% of respondents selected encouraging abstinence as important for addressing substance use. It may be useful for public health programs and services to better understand how professionals articulate the congruency of such actions with a public health approach to substance.

There are other survey findings relevant to CPHA's project aims. In particular, to support the development of knowledge products and capacity-building resources, including new tools on reducing the stigma associated with substance use. While 67% of the national sample rated their knowledge of how stigma affects people who use substances as "high", a notable 29% rated their knowledge as "intermediate" and 3% indicated "low". In response to the survey's open-ended question about topics that require more training and resources, many respondents explicitly mentioned stigma reduction – as well as TVIP and harm reduction, both of which are principles and areas of practice that are strongly supported by respondents. Together, these findings suggest there are indeed key needs and stakeholder desires for multi-sector training and education about the impacts of stigma associated with substance use.

Survey respondents also endorsed varied beliefs about why people use psychoactive substances. Over 90% selected each of the following belief options: stress; response to trauma or violence; social or recreational purposes; pleasure; and dependence/addiction. That said, other options such as pain, medical and therapeutic purposes and cultural activities were strongly endorsed. Furthermore, 10% of respondents selected lack of willpower as a belief, though it is important to note that some respondents explicitly challenged this notion as stigmatizing.

Also relevant to our understanding of current beliefs is the fact that 84% of respondents had witnessed misperceptions or misunderstandings about substance use that lead to preventable harms and 52% agreed people should accept responsibility for the impact of substance use on friends and family. These experiences and beliefs do not necessarily contradict one another and can co-exist within the same individuals and the same organizations. This is an indication that divergent beliefs about substance use and appropriate responses to substance use exist (Davis & Hawk, 2015; Luke et al., 2002). These survey findings may further suggest a need for resources on stigma reduction that promote open and honest discussion about misunderstandings and beliefs about personal accountability for substance use.

While the present survey was not designed to link different personal and professional experiences with distinct beliefs about substance use, it is notable that 45% of respondents indicated they use or have used psychoactive substances themselves. Canadian data suggests CPHA survey respondents may have underreported their consumption. For example, results from a recent Canadian Alcohol and Drugs Survey (Government of Canada, 2019) showed 76% of Canadians reported consuming alcohol in the past year.

There could be multiple reasons for this underreporting. The question about personal experience with substance use appeared near the beginning of the survey. Some respondents may have been reluctant to disclose personal consumption early on or in general. It is also possible some respondents applied a narrow lens regarding their own substance use in the context of this question (e.g., they may have considered only unregulated substances, rather than legally-regulated substances such as alcohol and nicotine). Underreporting of personal experiences and consumption of substances, and the possible interpretation of this question as pertaining only to legally-regulated substances, indicate that more efforts to normalize conversations about substance use may be beneficial among those who work in public health, public safety and other professions. In future CPHA surveys, the question about personal experiences relating to substance use could be more explicit in the scope of substances and better convey the reasons this question was included. This discussion also presents an opportunity to remind participants that survey data is completely de-identified in analysis.

Another valuable survey finding was about organizational barriers to implementing a public health approach to substance use. Although 6% of respondents indicated their organization was "very unlikely" to implement a public health approach to substance use, a further 7% indicated their organization was "somewhat unlikely" to do so. In addition, 30% indicated their organization was only "somewhat likely" to implement such an approach. In their open-ended answers, respondents often mentioned a lack of organizational and government support and/or dedicated resources as barriers to fulsome implementation of a public health approach to substance use. Similarly, numerous respondents – especially those who indicated an intermediate level of comfort with applying a public health approach to substance use in their work and those working in the government sector – noted they had observed lack of support from their colleagues, organization and/or agency partners.

Some respondents explicitly pointed out challenges with initiating and carrying out conversations about a public health approach to substance use in the context of such barriers. Organizational and political resistance to adopting more public health-focused approaches to substance use are not new, especially in literature that highlights harm reduction programs and practices as crucial public health strategies (e.g., Kerr et al., 2017; Strike & Watson, 2019). Nonetheless, it is important to document that this kind of resistance continues in Canada. These findings are also highly relevant to CPHA's project aims to normalize conversations about substance use and reduce stigma and to build the needed knowledge and capacity to effectively respond to substance use.

Limitations

Limitations of the present study include the use of selective sampling procedures (i.e., organizational channels and contacts were used to disseminate the survey and recruit respondents). This strategy resulted in uneven geographic, key sector and occupational representation. Survey findings are thus not transferable to the full spectrum of public health and public safety professionals across Canada. For instance, Ontario was selected most often (by 37% of the sample) as location of work. Participation was very low in some provinces and territories (e.g., 1% in the Yukon and in Newfoundland and Labrador) and was absent from three jurisdictions (i.e., Northwest Territories, Nunavut and Prince Edward Island). Greater proportions of the sample selected health care (43%) and public health (23%) among their primary sectors, compared to the selection of other sectors. Given survey recruitment design, these sample characteristics are perhaps unsurprising because CPHA's primary location is in Ottawa and has strong connections to Canadian health- and public health-related agencies.

Multiple efforts were made to reach a greater number of public safety and other professionals during 2021 when the survey was open (e.g., additional outreach to specific organizations). Future national survey dissemination should include more efforts to reach respondents across all jurisdictions, especially in the territories and Atlantic provinces. Organizational time constraints and shifts in priorities – especially in view of the COVID-19 pandemic measures in place at the time – may have also impacted the ability of some agencies and stakeholders to hear about and participate in the survey. Lastly, many survey questions offered respondents the opportunity to select all applicable options. This question format is efficient in online surveys, especially when asking about numerous beliefs and knowledge of different services and approaches; at the same time, this format can yield some analytical challenges and different estimates compared to forced-choice question formats (e.g., Callegaro et al., 2015). Nonetheless, CPHA's survey design covered a wide range of topics about knowledge and beliefs about substance use and, uniquely, understandings of a public health approach to substance use.

Conclusions and next steps

This survey report represents an important component of CPHA's multi-year project to engage professionals and communities across Canada in order to enhance their knowledge and capacity to implement a public health approach to substance use. CPHA will continue this work, drawing on evidence reviews and stakeholder consultations, including further developing its evolving definition of a public health approach to substance use. The national survey used a succinct definition to facilitate respondent sharing of their understandings of and reactions to a public health approach to substance use. At present, CPHA's longer and more nuanced definition states that a public health approach to substance use:

- Respects the autonomy and right to self-determination of people who use substances.

- Works to protect and promote the freedom, health, wellness and safety of people who use substances.

- Supports the underlying determinants of health and addresses health inequities.

- Acknowledges substance use exists on a spectrum, with both harms and benefits and focuses on reducing potential harms and maximizing potential benefits.

- Works to end stigma and discrimination.

- Recognizes and collaborates with people with lived and living experience of substance use as experts and fairly compensates them for their work.

- Is trauma- and violence-informed, gender transformative, anti-racist, anti-oppressive and culturally safe.

- Approaches substance use through a health and human rights framework, not a criminal justice framework, while acknowledging the historic and current harms of drug policy.

- Is collaborative and comprehensive and includes a continuum of programs and services that meet people where they are at.

- Is pragmatic and evidence informed.

Regarding next steps for the larger project, CPHA has developed the Canadian Substance Use Resource and Knowledge Exchange Centre (SURE) website. More information about SURE is available here: https://substanceuse.ca/.

This website contains a curated collection of tools and resources that support communities to implement a public health approach to substance use. SURE facilitates practitioners, policy-makers, program planners, workers with lived and living experience and other professionals to learn ways that inform practice transformation and build capacity in communities for a public health approach to substance use.

CPHA will also continue to develop specific tools and resources for professionals and practitioners about a public health approach to substance use, with a strong focus on stigma reduction. At the time of report writing, CPHA had completed an organizational assessment tool to help organizations identify policies and factors that contribute to stigma and discrimination in relation to substance use and to facilitate development of strategies to promote safer and more supportive environments for people who use substances. For more information, download the assessment tool.
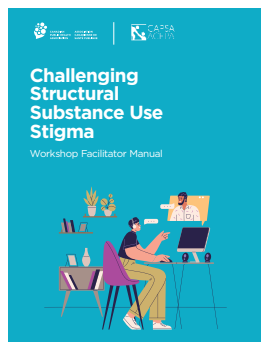
Also at the time of writing, CPHA was developing a full-day workshop on structural substance use stigma for health and social service providers across Canada. This workshop aims to address the capacity needs identified from the national survey as well as from key informant interviews conducted across Canada and three community assessments completed in Manitoba, Ontario and Nova Scotia. CPHA will also release a series of webinars on topics identified from the national survey before the project officially completes its funding cycle at the end of 2023.

All future tools and learning opportunities will be made available on the SURE website, along with project updates. Project updates and deliverables are also added to CPHA's project page.

References

Biancarelli, D. L., Biello, K. B., Childs, E., Drainoni, M., Salhaney, P., Edeza, A., Mimiaga, M. J., Saitz, R., & Bazzi, A. R. (2019). Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug and Alcohol Dependence*, 198, 80-86.

Braun, V., & Clarke V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Callegaro, M., Murakami, M. H., Tepman, Z., & Henderson, V. (2015). Yes–no answers versus check-all in self-administered modes: A systematic review and analyses*. International Journal of Market Research*, 57(2), 203-223.

Canadian Centre on Substance Use and Addiction. (2019). *Overcoming stigma through language: A primer.* Ottawa, ON: Canadian Centre on Substance Use and Addiction.

Canadian Public Health Association. (2014). *A new approach to managing illegal psychoactive substances in Canada.* Ottawa, ON: Canadian Public Health Association.

Canadian Public Health Association. (2017). *Public health: A conceptual framework.* Ottawa, ON: Canadian Public Health Association.

Crépault, J-F., Russell, C., Watson, T. M., Strike, C., Bonato, S., & Rehm, J. (2023). What is a public health approach to substance use? A qualitative systematic review and thematic synthesis. *International Journal of Drug Policy*, 112, 103958.

Davis, D., & Hawk, M. (2015). Incongruence between trauma center social workers' beliefs about substance use interventions and intentions to intervene. *Social Work in Health Care*, 54(4), 320-344.

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). Internet, phone, mail, and mixed mode surveys: The tailored design method (4th ed.). John Wiley & Sons Inc.

Government of Canada. (2019). Canadian Alcohol and Drugs Survey (CADS): Summary of results for 2019. Ottawa, ON: Government of Canada.

Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: Past, present, and future. Harm Reduction Journal, 14, 28.

Krosnick, J. A., & Presser, S. (2010). Question and questionnaire design. In J. D. Wright & P. V. Marsden (Eds.). Handbook of survey research (2nd ed.). San Diego, CA: Elsevier.

Livingston, J. D., Adams, E., Jordan, M., MacMillan, Z., & Hering, R. (2018). Primary care physicians' views about prescribing methadone to treat opioid use disorder. *Substance Use and Misuse*, 53(2), 344-353. https://doi.org/10.1080/10826084.2017.1325376

Loheswaran, G., Soklaridis, S., Selby, P., & Le Foll, B. (2015). Screening and treatment for alcohol, tobacco and opioid use disorders: A survey of family physicians across Ontario. *PloS one*, 10(4), e0124402.

Lowis, M. M., Harrison, J., & Wiland, S. (2019). Becoming an evidence-based practitioner. *Community Mental Health Journal*, 55(1), 24-30.

Luke, D. A., Ribisl, K. M., Walton, M. A., & Davidson, W. S. (2002). Assessing the diversity of personal beliefs about addiction: Development of the addiction belief inventory. *Substance Use and Misuse*, 37(1), 89-120.

Mahon, L. R., Hawthorne, A. N., Lee, J., Blue, H., & Palombi, L. (2018). Assessing pharmacy student experience with, knowledge of and attitudes towards harm reduction: Illuminating barriers to pharmacist-led harm reduction. *Harm Reduction Journal*, 15(1), 57.

McNeely, J., Kumar, P. C., Rieckmann, T., Sedlander, E., Farkas, S., Chollak, C., Kannry, J. L., Vega, A., Waite, E. A., Peccoralo, L. A., Rosenthal, R. N., McCarty, D., & Rotrosen, J. (2018). Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: A qualitative study of patients, providers, and staff. *Addiction Science and Clinical Practice*, 13(1), 8.

Mendiola, C. K., Galetto, G., & Fingerhood, M. (2018). An exploration of emergency physicians' attitudes toward patients with substance use disorder. *Journal of Addiction Medicine*, 12(2), 132-135.

Murney, M. A., Sapag, J. C., Bobbili, S. J., & Khenti, A. (2020). Stigma and discrimination related to mental health and substance use issues in primary health care in Toronto, Canada: A qualitative study. *International Journal of Qualitative Studies on Health and Well-being*, 15(1), 1744926.

Necyk, C., Cor, K., Mazzuca, A., & Meleshko, L. (2019). An evaluation of Alberta pharmacists' practices, views and confidence regarding prescription drug abuse and addiction within their practice setting. *Canadian Pharmacists Journal / Revue des pharmaciens du Canada*, 152(6), 376-387.

Nichols, T. R., & Gringle, M. R. (2020). The role of bias in knowledge translation: Lessons learned from a dissemination of best practices in maternal opioid use. *The Journal of Continuing Education in the Health Professions*, 40(3), 169-175.

Public Health Agency of Canada (2020). *A primer to reduce substance use stigma in the Canadian health system*. Ottawa, ON: Public Health Agency of Canada.

Reichert, J., & Gleicher, L. (2019). Probation clients' barriers to access and use of opioid use disorder medications. *Health and Justice*, 7(1), 10.

Ross, C. A., Berry, N. S., Smye, V., & Goldner, E. M. (2018). A critical review of knowledge on nurses with problematic substance use: The need to move from individual blame to awareness of structural factors. *Nursing Inquiry*, 25(2), e12215.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health*, 33, 77-84.

Schaeffer, N. C., & Presser, S. (2003). The science of asking questions. *Annual Review of Sociology*, 29, 65-88.

Schmidt, R., Wolfson, L., Stinson, J., Poole, N., & Greaves, L. (2019). *Mothering and opioids: Addressing stigma and acting collaboratively*. Vancouver, BC: Centre of Excellence for Women's Health.

Sightes, E., Ray, B., Paquet, S. R., Bailey, K., Huynh, P., & Weintraut, M. (2019). Police officer attitudes towards syringe services programming. *Drug and Alcohol Dependence*, 205, 107617.

Strike, C., & Watson, T. M. (2019). Losing the uphill battle? Emergent harm reduction interventions and barriers during the opioid overdose crisis in Canada. *International Journal of Drug Policy*, 71, 178-182.

Venner, K. L., Sánchez, V., Garcia, J., Williams, R. L., & Sussman, A. L. (2018). Moving away from the tip of the pyramid: Screening and brief intervention for risky alcohol and opioid use in underserved patients. *Journal of the American Board of Family Medicine*, 31(2), 243-251.