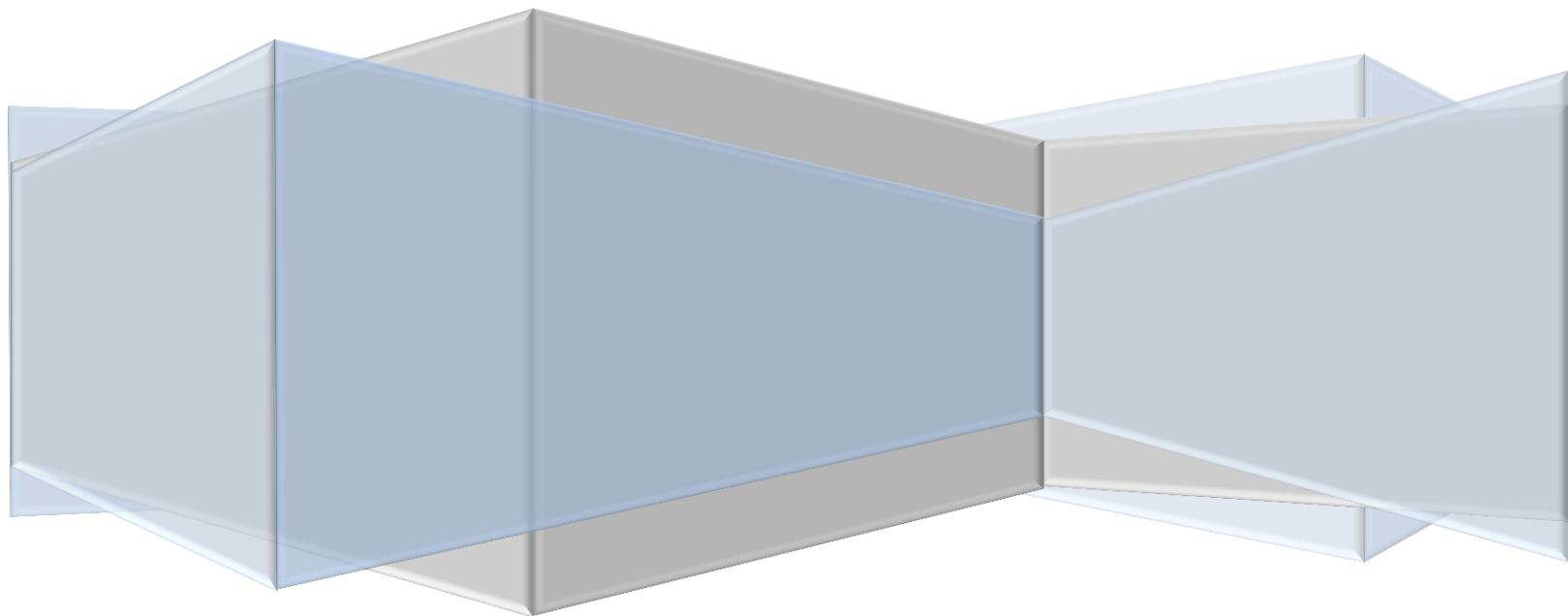


BRITISH COLUMBIA OVERDOSE ACTION EXCHANGE

Supplementary Material: Primers

JULY 2016



CONTENTS

1.	Drug Use and Harms Surveillance	4
2.	Naloxone	6
3.	Emergency Departments and First Responders	9
4.	Supervised Injection Site	12
5.	Supervised Consumption sites and the Section 56.1 exemption process.....	15
6.	Overdose Trends and Toxicology	17
7.	Drug Checking.....	19
8.	Opioid Agonist Treatment.....	22
9.	Injectable Opioids as Treatment.....	25
10.	Inpatient Withdrawal Management and Residential Treatment	28
11.	Co-Occurring Mental Health & Substance Use Disorders	31
12.	Prescription Opioids	34
13.	Public Health Based Opioid Management and Regulation.....	38
14.	Drug Policy and Overdose	41
15.	Drug Enforcement	43
16.	Corrections.....	46
17.	The Role of Peers	48
18.	First Nations Off Reserve.....	50
19.	Engaging First Nations in Community and Away from Home	52
20.	Primary Care Providers.....	55
21.	Harm Reduction and Cultural Shifts	57
22.	Stigma and Persons Who Use Drugs.....	60
23.	Overdose Impact On Families	62
24.	Youth Overdose Prevention	64
25.	The Role of Community in Overdose Prevention.....	67
	Additional Materials.....	70

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The following Primers were produced to provide the participants of the BC Overdose Action Exchange that took place on 9th June 2016 at BCCDC a baseline understanding of the issues to be addressed as part of the meeting. They are included to provide background to the issues discussed as part of the meeting and the areas of action identified.

Primers are presented for discussion only and the views and opinions expressed are those of the authors and do not necessarily reflect those of any organization or agency

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1. DRUG USE AND HARMS SURVEILLANCE

Prepared by: Brian Emerson, MD, Medical Consultant, BC Ministry Of Health

BC does not have a coordinated, comprehensive and effective population and public health surveillance program for problematic drug use and harms, in the same way that such a program exists for communicable disease surveillance.

BACKGROUND

Population and public health surveillance is a core underpinning of effective public health programs. Surveillance comprises the ongoing collection, analysis, interpretation, and dissemination of health-related data and information to support planning, implementation, evaluation, and improvement of public health practices. Adequately resourced surveillance programs, with the flexibility to respond to surge demands, are required to support public health and related policy, planning and evaluation to protect and promote the health of the public.

BARRIERS AND OPPORTUNITIES

In a review of opioid use and harm surveillance, researchers from the UBC Centre for Health Services and Policy Research (Dr. Kate Smolina, Emilie Gladstone, and Dr. Steven Morgan) identified a number of surveillance considerations, including:

Data Collection

- Make better use of PharmaNet data.
- Enable easier access to BC Coroner's Data to public health officials and researchers.
- Explore linkage and/or integration opportunities between the BC Drug and Poison Information Centres, Injuries Unit, BC Coroners Service, addiction treatment system, CARBC surveys, WorkSafe BC, and others.

Analysis

- Make an institutional focal point where data analysis (and potentially data storage) occurs (e.g. BCCDC; PHSA; or one of BC Universities). The chosen institution should have epidemiologists with experience in surveillance activities and the capacity to perform these functions.
- Automate as many functions as possible in order to reduce the cost of human resources.

Interpretation

- Set up an advisory group that would meet regularly to review surveillance output and make decisions on any necessary action items.

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Reporting

- Identify a set of standard metrics for each data source that will be used to measure drug use and harms.
- Generate regular (weekly or monthly) reports to be disseminated to all relevant stakeholders.

Evaluation

- Track specific measures of performance, for example: data flow, quality, and representativeness to ensure data from multiple sources is transferred rapidly and accurately from all relevant data holders; acceptability of the system to key stakeholders; simplicity of use; and automation of data collection and reporting.
- Include outcomes evaluation to measure the impact of the system.
- Measure unintended consequences of interventions.
- Regularly perform a cost benefit assessment of having included data source as part of a surveillance system.

Further to the above, the Drug Overdose Awareness Partnership has planted the seeds of a surveillance program at BCCDC and in the health authorities. The reporting of overdoses from emergency departments, ambulance calls, and coroners is further driving surveillance program development. A logical next step could be to build on these foundations by adequately funding a hub and spoke model, using the Public Health Observatory model already developed, to establish an organized coordinated, comprehensive and effective population and public health surveillance program for problematic drug use and harms. As current resources are already strained, additional resources are needed to cope with current expectations, and to fully develop the program.

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1. Pharmaceutical opioid monitoring and surveillance in British Columbia: Current state and future directions
<https://open.library.ubc.ca/cIRcle/collections/ubccommunityandpartnerspublicati/47136/items/1.0048537>
2. Population and Public Health Surveillance Plan for British Columbia Part 1: Current State
3. Population and Public Health Surveillance Plan for British Columbia Part 2: Implementation Strategy

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2. NALOXONE

Prepared by: Jane Buxton, MD, Physician Lead for Harm Reduction at BC Centre for Disease Control

The use of naloxone to reverse opioid overdose and naloxone availability in BC

BACKGROUND

Naloxone, or Narcan®, is an antidote to opioid overdose. Naloxone reverses the effects of opioids by preferentially binding to receptor sites in the brain and temporarily preventing the opioids from having an effect. The protective effect lasts for 30 to 90 minutes, so if large dose or long-acting opioids are used additional doses of naloxone may be required. The primary mechanism for administration of naloxone is by injection; intranasal applications are also available but not currently licensed in Canada.

Naloxone is on the World Health Organization List of Essential Medicines and has been in use in Canada for over 40 years. Naloxone has no pharmaceutical effect in the absence of opioids. Naloxone will not get a person high. Research shows naloxone does not encourage opioid use but may cause individuals dependent upon opioids to develop withdrawal symptoms upon administration.

Naloxone does not work for non-opioid overdoses (like cocaine, ecstasy, GHB or alcohol). However, if an overdose involves multiple substances, including opioids, naloxone helps by temporarily removing the opioid from the equation.

Having naloxone available in the community as well as through all first responders enable opioid overdoses to be reversed promptly to avoid brain damage due to lack of oxygen and death.

Naloxone Availability in BC

Naloxone administration in BC was previously limited to paramedics whose ambulance attended 911 calls and who were level 4 trained, and to use in hospitals including emergency departments.

The BCCDC implemented the Take Home Naloxone (THN) program in August 2012 to provide naloxone kits to individuals in the community who use opioids to enable timely reversal of opioid overdose while waiting for emergency services to arrive. In April 2015, in collaboration with BC College of Registered Nurses, a decision support tool was developed to allow nurses to dispense naloxone without a prescription.

The THN program has grown to more than 269 distribution sites across BC, including 34 emergency departments and 3 provincial correctional facilities. More than 10,973 kits have been distributed and over 1,691 overdose reversals have been documented since the program's inception.

On January 28, 2016 BC Emergency Health Services announced that all ambulance crew (including level 3 trained paramedics) could carry and administer naloxone and fire rescue crews could carry naloxone once a collaboration agreement between the fire service and local municipality was in place and the firefighter appropriately trained.

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Naloxone is not currently covered by BC Pharmacare, but most third party private insurance companies will reimburse patients for their naloxone prescription.

On March 22, 2016, Health Canada revised the Federal Prescription Drug List to make non-prescription naloxone available. Two days later the College of Pharmacists of BC announced naloxone was listed as a schedule II drug making it available to members of the public without a prescription from behind-the-counter. This designation ensures an assessment by the pharmacist occurs prior to sale and allows for individuals who don't use opioids, but support individuals who do (e.g. parents, partners or friends) and people who do not wish to attend THN site to obtain naloxone. Over 1,000 pharmacists were trained in one week. Pricing of naloxone through BC pharmacies has not been standardized and varies widely (from \$15 to \$100 per dose) naloxone kits have been developed for purchase at pharmacies.

The BCCDC has been in discussion with the BC Ministry of Health, Pharmaceutical Division about adding naloxone to the provincial formulary for over four years; to date these efforts have been unsuccessful.

BARRIERS AND OPPORTUNITIES

Until recently naloxone for use in the community has been available only to those who use opioids and only in geographies that have THN distribution sites working with the BCCDC program. The move to designate naloxone a schedule II drug has the potential to increase the population with availability to access naloxone, but the high cost in some areas and lack of PharmaCare coverage are significant barriers to getting naloxone in the hands of populations that would benefit from it.

The expansion of the THN to distribution through emergency departments provides the opportunity to provide individuals at high risk of overdosing with kits, but the distribution of kits through this channel and associated training requirements to support department staff is reliant upon the limited resources of the THN program and regional harm reduction coordinators, and is well outside of the original scope of the BCCDC THN program.

Areas that Require Action

- There is a need to establish additional THN distribution sites in underserved areas of BC
- Support expansion of THN to persons at risk of opioid overdose following periods of reduced use/abstinence e.g. on release from correctional centres, residents at halfway houses and those leaving recovery, detoxification and treatment centres.
- Expansion of THN distribution to all emergency departments
- Addition of naloxone to the provincial formulary

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<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4183165/pdf/cmajo.20140008.pdf>

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BC Emergency Health Services. Fire rescue crews to carry naloxone for drug overdose patients <http://www.bcehs.ca/about/news-stories/news-roll/fire-rescue-crews-to-carry-naloxone-for-drug-overdose-patients>

BC THN program infographic updated monthly: <https://infograph.venngage.com/p/1974/naloxone-infograph>

BCCDC Non-certified Practice Decision Support Tool Dispensing naloxone <http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/NaloxoneDispensingDSTforNurses.pdf>

College of Pharmacists of BC webinar and training materials available under 'resources' at <http://www.bcpharmacists.org/naloxone>

World Health Organization. Community management of opioid overdose. Available at: http://apps.who.int/iris/bitstream/10665/137462/1/9789241548816_eng.pdf?ua=1&ua=1

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3. EMERGENCY DEPARTMENTS AND FIRST RESPONDERS

Prepared by: Roy Pursell, MD, Medical Lead, BC Drug and Poison Information Centre

Management of Opioid Overdose Patients: First Responders and Emergency Department Personnel

BACKGROUND

First responders and emergency department personnel care for patients with opioid overdoses. When an overdose occurs, it is important for a 911 emergency call to be made so that the first responders can provide resuscitative care. Some first responders can provide naloxone, the antidote to opioid overdose. Patients will be taken to emergency departments for further treatment. If the patient has continued respiratory depression, respiratory support will be provided and additional doses of naloxone will be administered. Complications secondary to the opioid overdose such as fentanyl-induced chest rigidity, acute lung injury and cardiac dysrhythmias will be treated. Patients will be observed in the emergency department for several hours to ensure they do not develop delayed toxicity. Some patients may require admission to an inpatient hospital ward.

BARRIERS AND OPPORTUNITIES

1. Development and refinement of patient management guidelines for patients with overdoses of ultrapotent opioids.

Many opioid overdoses are now caused by fentanyl or other ultrapotent opioids. In the past most opioid overdoses in illicit circumstances were caused by heroin. Preliminary data from the BC Coroners Service suggest that the proportion of illicit drug overdose deaths for which fentanyl was detected increased to 49% in the first 3 months of 2016. Other ultrapotent opioids have been detected in samples collected from patients who have died from drug overdose. The management of patients who have taken an overdose of an ultrapotent opioid differs from the management of patients who have overdosed on heroin in the following ways:

Naloxone Dose - Some patients with overdoses of fentanyl require large doses of naloxone for reversal. The authors of one study found that the mean dose of naloxone required to reverse a fentanyl overdose was 3.4 mg. However, in many patients with opioid overdose, adequate reversal of opioid toxicity will occur with smaller doses of naloxone. Excessive doses of naloxone will result in precipitated acute opioid withdrawal syndrome. Naloxone-precipitated acute opioid withdrawal syndrome is associated with a series of life-threatening adverse events. Until further empiric testing of naloxone dosing is completed, it is reasonable to use the following naloxone dosing approach:

Indications for naloxone: Respiratory rate < 12 /min or oxygen saturation < 92% on room air OR fentanyl induced chest rigidity

Routes of administration: IV/IO preferred. IM/SC if IV/IO access is not available.

Initial dose: Adults: 0.1 mg IV/IO or 0.4 mg IM if no IV/IO; Pediatrics: 0.1 mg/kg IV/IO/IM of body weight (to a maximum of 2mg)

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Subsequent dosing: If there is no response to 0.1 mg IV, subsequent doses should be administered every 2 minutes (3 minutes if IM) according to the following schedule: 0.4 mg, 0.4 mg, 2.0 mg, 4.0 mg, 10 mg

Consider administering 15mg as a final dose if there is a very high index of suspicion

Goals of naloxone therapy: RR \geq 12/min, GCS > 10, no acute withdrawal symptoms precipitated.

Observation time – The duration of action of fentanyl in the overdose setting is not known but may be several hours. Prolonged observation will be required.

Chest wall rigidity – It is possible that fentanyl-induced chest wall rigidity is a factor in rapid death from fentanyl. The effects may be reversed by administration of naloxone. Neuromuscular paralysis, intubation and intensive care unit care may be required in order to manage patients with this condition.

A “Best Practices” management guideline has been developed after an extensive review of the literature and a consultation process.

2. Setting up a knowledge translation process so that all physicians and first responders caring for patients who have overdosed on ultrapotent opioids have information on “Best Practices” for management.

A “Best Practices” management guideline has been posted on the website of the University of British Columbia, Department of Emergency Medicine website. A webinar has been completed and viewed by physicians practicing at multiple sites. Additional knowledge translation activities will need to be completed.

3. Completing studies to answer important unanswered questions about the management of patients who have taken an overdose of an ultrapotent opioid.

Physicians and first responders have a great deal of experience with the management of patients with heroin overdose and there is an extensive body of knowledge to guide care. This is not the case for fentanyl and other ultrapotent opioids. In order to optimize our management guidelines we will need to complete studies to determine the answer to many questions including the following:

- What are the mean and median doses of naloxone required to reverse toxicity caused by fentanyl and other ultrapotent opioids?
- What is the incidence of clinically significant re-intoxication following naloxone and what is the timing of this recurrence?
- What is the most effective way to complete counselling and education on overdose prevention, recognition and response and the use of take home naloxone?

In order to complete these studies it will be necessary to set up a data collection process. Funding and ethical approval for the studies will need to be obtained. This will be a workload and logistics challenge.

4. Increased first responder and emergency department workload and increased emergency department overcrowding.

The care of patients who have taken an overdose of an ultrapotent opioid is more complex and more labour intensive than the care of patients who have taken an overdose of heroin. The requirement for longer observation times will result in increased emergency department overcrowding.

5. Difficulty providing the education on overdose prevention, recognition, response and the use of take home naloxone to all patients who are treated in the emergency department and require this counselling.

The ED represents an ideal opportunity to identify patients who might benefit from take home naloxone. Some users may have difficulty obtaining naloxone from any source other than the emergency department. Patients should receive education on overdose recognition and response and the use of take home naloxone. Patients should also be offered counselling on overdose prevention. However, there is a limited time frame in which patients who have taken an overdose of opioids are available and receptive to counselling and education. Patients may be having difficulty dealing with a series of medical, social and psychological problems. There will be times in which they are unable or unwilling to engage in education programs. They may decide to discharge themselves from hospital against medical advice after a short hospital stay. However, emergency department staff are generally extremely busy and are routinely interrupted. In one study it was found that emergency physicians are interrupted every 6 minutes on average. It would be optimal if personnel who did not have other pressing clinical care responsibilities were available to provide the necessary education and counselling.

6. Ensuring that 911 is called when a patient has an opioid overdose and addressing the challenges that first responders face providing care to patients.

Patients with overdoses of opioids require emergency department care and education and counselling. It is important that 911 is called so the patient is transported to hospital and receives this care. It is important to make sure that the scene of the overdose is safe and secure so that first responders can provide life-saving care to the patient rapidly. Large doses of naloxone are required for reversal of some ultrapotent opioids. The paramedics will have to decide if it is better to focus on transporting the patient to hospital or to focus on rapidly providing additional doses of naloxone. The management of fentanyl-induced chest wall rigidity will be very challenging in the prehospital setting.

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Schumann H, Erickson T, Thompson TM et al. Fentanyl epidemic in Chicago Illinois and surrounding Cook County. Clin Tox 2008;46:501-506.

Boyer EW. Management of Opioid Analgesic Overdose. New England Journal of Medicine 2012;367:146-155.

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4. SUPERVISED INJECTION SITE

Prepared by: Thomas Kerr, PhD, Director, Urban Health Research Initiative, BC Centre for Excellence in HIV/AIDS; Professor, Department of Medicine, University of British Columbia

Use of supervised injection sites in BC

BACKGROUND

Supervised injection sites (SISs) are healthcare facilities where people who inject drugs (PWID) can inject pre-obtained illicit drugs under the supervision of nurses or other healthcare professionals. Within SISs, PWID are provided with sterile injecting equipment (syringes, alcohol swabs, cookers, etc.), as well as safer injecting education, emergency response in the event of overdose, and referrals to internal and external health and social services.

There are over 90 SISs operating throughout the world in approximately 66 cities in 10 countries, including in Western Europe and Australia. SIS programs take on many forms, including: large stand-alone facilities designed specifically for the supervision of drug injecting; smaller integrated SISs within larger healthcare facilities; and mobile services operating out of vans. Further, several supervised inhalation rooms, where individuals can inhale drugs, also operate presently in Europe.

SISs have been subjected to rigorous evaluation in various settings, although most of the existing SIS literature has been derived from the evaluation of Insite in Vancouver. The Vancouver SIS evaluation revealed many benefits of Insite, including: declines in public injecting; reductions in fatal overdose; reductions in HIV risk behaviour; increases in uptake of detoxification and addiction treatment services. The evaluation also found no negative impacts in terms of increased crime, initiation into injecting, relapse into injecting, and Insite was found to be cost-effective. Evaluations undertaken in Australia and Europe also have shown: declines in ambulance call-outs; high rates of referral to external services; declines in syringe sharing; and one ecological study from Germany found lower rates of overdose death in cities with SIS compared to cities without SIS.

Supervised Injection Site Availability in BC

Presently, there is one large SIS in Vancouver's Downtown Eastside (known as "Insite") and one small SIS in the West End at the Dr. Peter Centre, which is available only to individuals living with HIV/AIDS who are members of the Centre. Access to SIS programming remains non-existent in most locations in BC, including in the Lower Mainland. The available evidence suggests that PWID will not travel long distances to use a SIS, and the majority of PWID who use Insite on a regular basis live within 3 blocks of the facility, making the geographic coverage of individual SIS programs very limited.

There is a growing body of evidence pointing to problems associated with drug use within hospitals. In-hospital drug use has been associated with leaving hospital against medical advice, as well as other risks and challenges for PWID and hospital staff. A recent study showed that 68% of Vancouver PWID were

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willing to use an in-hospital SIS, and those who reported in-hospital drug use were among those most likely to report such willingness. At this time there are no SISs within hospitals in BC. SISs have also been integrated into other pre-existing facilities in Europe, including in supportive housing programs, community health clinics, and in drop-in centres. Aside from the Dr. Peter Centre site, there are at present no integrated models of SIS in BC or elsewhere in Canada.

Mobile SISs have now been established in many European cities to increase the coverage of supervised injecting programming. These may be particularly helpful in reaching PWID who are more street-entrenched and those who use drugs in locations far away from fixed SISs. There are no mobile SISs in BC at this time. Several European cities have also implemented supervised inhalation rooms, although no such facilities exist in BC.

BARRIERS AND OPPORTUNITIES

Access to SIS programming in BC remains extremely low. Among the greatest barriers to the implementation of new SISs is federal legislation (Bill C-2), which sets out a number of criteria that must be met in order to obtain the Section 56 exemption needed to legally operate a SIS. The current exemption process remains extremely onerous and is limited to individual sites. Opportunities to obtain more blanket exemptions (e.g., for several SISs within an existing health authority) are not currently within reach.

People who require assistance with injections are a particularly high risk group of PWID. Such individuals are known to be heightened risk for HIV infection, overdose and violence. However, existing legislation prohibits assisted injecting within SISs, and therefore this highly vulnerable group remains unable to access SISs in BC.

Although SISs in BC and elsewhere have been subjected to rigorous evaluation and found not to produce negative effects such as increases in crime or public disorder, some opposition to SISs remains and a small group of stakeholders continue to disseminate misinformation about SISs. This in turn fuels public concern about such facilities, which can be problematic given that federal legislation requires local community support before a new SIS can be established.

Areas that Require Action

- There is a need to obtain exemptions to implement new SISs in settings throughout BC where injection drug use is prevalent;
- SISs should be integrated within hospitals and other programs serving PWID, including in community health clinics;
- Legal reform is needed to allow for assisted injecting within SISs;
- Opportunities for supervised inhalation programming should be considered;
- Bill C-2 should be rescinded or amended to allow for a more simple and streamlined exemption process.

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1. Wood E, Tyndall MW, Montaner JS, Kerr T. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. *CMAJ*. 2006;175(11):1399-1404.
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3. Ti L, Buxton J, Harrison S, et al. Willingness to access an in-hospital supervised injection facility among hospitalized people who use illicit drugs. *J Hosp Med*. 2015;10(5):301-306.
4. European Monitoring Centre on Drugs and Drug Addiction. Perspectives on drugs: Drug consumption rooms: an overview of provision and evidence. EMCDDA, 2015. Available at: http://apps.who.int/iris/bitstream/10665/137462/1/9789241548816_eng.pdf?ua=1&ua=1

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5. SUPERVISED CONSUMPTION SITES AND THE SECTION 56.1 EXEMPTION PROCESS

Prepared by: Mark Lysyshyn MD MPH FRCPC, Medical Health Officer, Vancouver Coastal Health and John Harding, MD, Addictions Medicine Fellow, St. Paul's Goldcorp Addiction Medicine Fellowship

The establishment of a Supervised Consumption Site (SCS) in Canada requires that an exemption under the Controlled Drugs and Substances Act (CDSA) be granted by the Federal Government via an application to the National Compliance and Exemption Division of Health Canada. Although SCS are supported by considerable evidence, the current application process is a barrier to expanding these much needed services.

BACKGROUND

Supervised Consumption Sites (SCS) originated in the Netherlands in the 1970s, with subsequent facilities emerging in Switzerland, Germany, Spain, Luxembourg, Norway and Australia. Insite, the first legally-operating SCS in North America, opened in Vancouver in 2003 followed by SCS at the Crosstown Clinic and Dr. Peter Centre. Exemptions to the Controlled Drugs and Substances Act (CDSA) were necessary to operate these sites. Exemptions for Insite were granted for periods of one year following an annual application process. However, in 2016 it received a four-year exemption. In 2016, the Dr. Peter Centre was granted its first exemption for a two-year period.

In 2011, the Supreme Court of Canada ruled that Insite has health benefits without any negative impacts on the community, and that this is adequate for Health Canada to grant an exemption. However, in June 2013, the Federal Health Minister introduced Bill C-2, the 'Respect for Communities Act', with 27 new requirements for the establishment of new SCS in Canada. This bill passed into law in June 2015. Under this legislation, the Federal Health Minister has sole discretion whether a new SCS can be established and whether already existing sites may continue to operate.

The CDSA is one of Canada's federal drug control statutes, intended to control substances that may result in harm to society when diverted or misused. It also provides a framework that allows access to those substances for legitimate purposes, such as for scientific or clinical research, laboratory testing, opioid substitution therapy, or medical marijuana production and possession. An exemption for SCS can be granted for activities with *illicit* substances [subsection 56.1(2)] via an application process, which requires the following criteria to be addressed:

- Site identification
- Scientific evidence
- Letters from stakeholders including Provincial Ministers of Health & Public Safety, Head of Police Force, Local government, and Lead Public Health Professional
- Measures to address concerns of public health and public safety
- Consultation with professional licensing authorities for physicians and nurses
- Community views

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- Information to support a need for the site
- Financial support
- Access to other health services
- Health, safety & security of clients, staff and local community
- Proposed personnel, including responsible person in charge, an alternate, & key staff members

There are currently several different models of SCS operating in BC. Insite provides an SCS available to the public; Dr. Peter Centre provides supervised consumption services to its existing clients; and Crosstown Clinic operates an SCS for research purposes. Other proposed models in Canada include a mobile SCS, the application for which was submitted by the City of Montreal in late 2015.

Moving forward, further SCS models are being envisioned that would allow integration of supervised injection into already-existing models of related health care delivery, such as that provided by community health centres and acute care programs. The benefits of integrating SCS into existing services include a reduction of safety hazards related to unsupervised injection, including overdose, infection and injury. SCS is expected to improve attendance of outpatient health care appointments as well as retention in inpatient care. In addition, SCS will reduce staff safety hazards from improperly discarded injection equipment in facilities as well as public safety from a reduction in discarded injection equipment in the community. Costs of integrating SCS into existing services include costs related to renovations required to accommodate supervised consumption services as well as costs associated with staff training. Lastly, a supply costs related naloxone and associated supplies is also to be expected.

BARRIERS AND OPPORTUNITIES

- The prohibitive nature of an onerous application process which must be completed for each individual SCS site and subsequent delay until approval.
- Current models of SCS are expensive. Alternatives to support expansion include integration with existing services and an exploration of peer-based SCS models.
- SCS with prescribed diacetylmorphine (heroin) would require a subsection 56.1(2) exemption for illicit substances however hydromorphone has recently been demonstrated as a valid alternative to heroin for opioid assisted therapy, however, an exemption *may* still be required under the first regime for *licit* substances [subsection 56.1(1)]. This is a potential barrier requiring legal clarification.

IMPORTANT REFERENCES

Controlled Drugs & Substances Act: <http://laws-lois.justice.gc.ca/eng/acts/c-38.8/>

Legislative summary of Bill C-2:

http://www.lop.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?Language=E&ls=C2&Mode=1&Parl=41&Ses=2&source=library_prb

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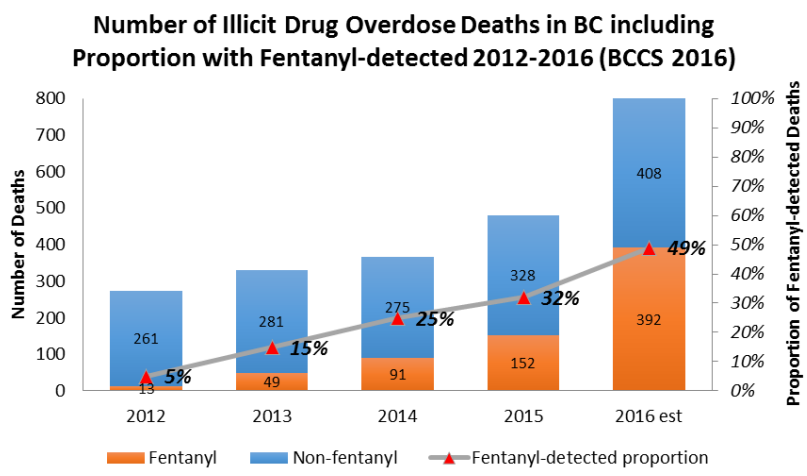
6. OVERDOSE TRENDS AND TOXICOLOGY

Prepared by: Mark Lysyshyn, MD MPH FRCPC, Medical Health Officer, Vancouver Coastal Health and John Harding, MD, Addictions Medicine Fellow, St. Paul’s Goldcorp Addictions Medicine Fellowship

In British Columbia, the number and population rate of unintentional illicit drug overdose deaths has been increasing at an alarming rate, with the trend accelerating in early 2016. The increasing detection of synthetic opioids such as fentanyl in illicit drug overdose deaths and the presence of fentanyl and related compounds such as fentanyl analogues and W-compounds in the illicit drug market is believed to be driving the current crisis.

BACKGROUND

In British Columbia, the number of unintentional illicit¹ drug overdose deaths has increased from 274 deaths in 2012 to 480 deaths in 2015. During this time, fentanyl has been detected in an increasing proportion of these deaths. In 2012, it was detected in 5% of deaths and by 2015 it was detected in 32%. As of the end of March 2016, a total of 200 illicit drug overdose deaths occurred in BC. Of those, fentanyl was detected in 98, leading to a current proportion of fentanyl-detected overdose deaths of 49%. With the current trend, up to 800 deaths are projected by the end of the year, with nearly half expected to involve fentanyl (see Figure 1).



Fentanyl is a synthetic opioid with a potency of action 20 to 40 times that of heroin. Although some diversion of pharmaceutical fentanyl has been known to occur in BC, the current situation is thought to be mostly due to unintentional consumption of drugs containing illicitly produced fentanyl. Illicit fentanyl is thought to be manufactured in clandestine overseas drug labs, imported into Canada, cut into powders or pressed into pills and sold on the street as heroin powder or opioid tablets. Although some drug users

¹ Illicit drug overdose includes: street drugs; medications not prescribed to the deceased; combinations of the former and the latter; and drugs with unknown origin

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may be seeking out fentanyl, most are not knowingly using it. In 2014, three quarters of drug users in BC who tested positive for fentanyl did not know that they had used it.

The adulteration or substitution of illicit opioids with fentanyl is not a new issue. In the 1970's, shortly after the discovery of pharmaceutical fentanyl, overdose deaths were associated with a potent new substance sold on the street as 'China White' heroin. Authorities in California eventually identified the substance as alpha-methylfentanyl, a compound twice as potent as fentanyl. Since that time, outbreaks of overdose deaths due to illicit fentanyl and related compounds (called fentanyl analogues) have occurred sporadically in multiple U.S. states. Removal of OxyContin from the pharmaceutical drug market in 2012 and its replacement with tamper-resistant OxyNeo may have played a role in the recent appearance of fentanyl in the North American illicit drug market.

More recently, novel chemicals such as the W-compounds have started to appear in the illicit drug market. These substances are chemically distinct from fentanyl and its analogues but have similar physiologic effects. W-18 was recently identified in a drug seizure in BC (in West Kelowna in March of this year). These compounds can be up to 100 times more potent than fentanyl. The effectiveness of the antidote naloxone to reverse the effects of an opioid agonist of this strength is unknown.

Current laboratory testing methods in BC are believed to be inadequate for detecting many fentanyl analogues and W-compounds in clinical samples, which may be leading to an under-estimation of the impact of illicit synthetic opioid agonists on the population. These substances have been identified locally via analysis of drug samples from police seizures conducted by the Health Canada Drug Analysis Service, a service available to law enforcement agencies but not health authorities.

BARRIERS AND OPPORTUNITIES

- The majority of people who use drugs in BC who test positive for fentanyl are not aware that they have taken fentanyl.
- Laboratories in BC possess differing protocols and abilities to detect fentanyl analogues and related substances, such as W-compounds leading to an incomplete picture of current drug trends.
- Current understanding of toxicological trends in BC comes from coroner's reports that contain only reporting on fentanyl and not other substances. Health authorities require more information on overdose toxicology and as well as drug testing results from Health Canada's DAS lab to gain a better understanding of illicit drug trends that are responsible for overdose deaths.

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BC Coroners Service: Illicit drug overdose deaths in BC, January 1, 2007 to April 30, 2016

<http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

BC Coroners Service: Fentanyl-detected illicit drug overdose deaths, January 1, 2012 to March 31, 2016

<http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf>

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7. DRUG CHECKING

Prepared by: Kenneth Tupper, PhD, Director, Problematic Substance Use Prevention at the BC Ministry of Health and Mark Lysyshyn, MD MPH FRCPC, Medical Health Officer, Vancouver Coastal Health

Drug checking: an integrated, multi-pronged, harm reduction outreach service that offers testing of samples of street drugs to determine their composition (including potential contaminants or adulterants) and allow for more informed decision-making by people who use drugs. It has been available in Europe since the 1990s, but is an underdeveloped public health response in Canada.

BACKGROUND

Drug checking is available in Austria, Belgium, France, Germany, the Netherlands, Spain and Switzerland. Australian officials are currently discussing a national pilot project, following a petition signed by over 35,000 people. Some drug checking services are at a fixed-site, or utilize an existing laboratory, whereby clients drop off samples and receive an identification code to check for results online within 24 hours; others provide on-the-spot access with mobile analytic equipment or more simplistic reagent tests.

Evaluation findings demonstrate that drug checking contributes to reducing unintentional drug overdoses and deaths by:

- Providing information quickly to clients to help them to avoid unintentionally consuming contaminated or adulterated psychoactive substances;
- Engaging hard-to-reach populations with preventive, harm reduction and overdose supports and resources;
- Increasing accountability between consumers and suppliers of illegal substances;
- Providing early warning concerning contaminated and/or high strength batches of products;
- Supporting the monitoring and surveillance of illegal drug markets.

Drug checking is a public health, consumer safety intervention that could help to reduce the number of Canadians who are harmed or die because illegal drugs they are taking are often contaminated, adulterated and of unknown potency. While the regulation of food and alcohol for consumer safety reasons dates back centuries, the production of illegal drugs remains clandestine, unregulated and unnecessarily risky for public health.

BARRIERS AND OPPORTUNITIES

The barriers to moving forward with this intervention include:

- Legal: Conducting an analytical test on a sample of a presumed controlled substance may require being (temporarily) in possession of a small amount of the substance; this may be interpreted as a contravention of the federal *Controlled Drugs and Substances Act*. In addition, drug checking services could be provided along with supervised injection services at legally exempted settings

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such as Insite, but the Section 56 exemption currently provided for the service is very narrowly circumscribed.

- Testing technologies/costs: Simple reagents (e.g. the Marquis test) are affordable, but not sufficiently specific (e.g. cannot identify fentanyl), cannot readily identify all contaminants or adulterants in a given sample and do not provide an accurate estimation of dosage. Raman spectroscopy and ion scanning technologies are more specific but do not work well with organic compounds such as heroin, require an operator and are more expensive. Gas chromatography/mass spectrometry or high performance liquid chromatography can provide both qualitative and quantitative analysis of a drug sample, but are much more expensive and require technical training to conduct, and may be more difficult to perform outside of laboratory settings.
- Mandate: The expertise and technology for testing street drugs exists in Health Canada's Drug Analysis Service laboratories, but their current mandate is to provide this service to police, not to public health officials or the general public.

The relative magnitude of these barriers depends on the technology. Simple technologies that can be used by drug users themselves typically present fewer legal and cost barriers but are more limited in terms of what they can detect. More advanced technologies that require a trained operator tend to present greater legal and cost barriers.

Efforts to address these barriers have been largely led by community-based groups who are committed to increasing safety at festivals and music events, relying heavily on online platforms. The AIDS Network Kootenay Outreach and Support Society (ANKORS) is the only organization so far in Canada that has provided onsite drug checking openly as part of its harm reduction program at the annual Shambhala music festival in BC. ANKORS is currently preparing a best practices manual for drug checking.

In addition, an informal national network has emerged that is actively pursuing the development of drug checking services in Canada. Activities include:

- A national meeting held in January 2015 by the Canadian Centre on Substance Abuse;
- A briefing prepared by the Canadian Students for Sensible Drug Policy;
- Regular teleconferences for over a year; and
- Efforts to tap into scientific expertise in the academic and private sectors, e.g., collaborating with university laboratories, testing whether existing urine dipsticks can be used to detect fentanyl in street drugs.

There is an urgent need for the collaborative (including health, harm reduction and enforcement) development and evaluation of pilot drug checking services in Canada. As yet, there is no clear lead on this work.

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8. OPIOID AGONIST TREATMENT

Prepared by: Emily Wagner, Thomas Kerr, PhD, Keith Ahamad, MD, Seonaid Nolan, MD and Cheyenne Johnson : The Network for Excellence in Substance Dependence and Related Harms and the BC Node of the Canadian Research Initiative in Substance Misuse (CRISM)

Maintenance opioid agonist treatment (OAT) is the most effective intervention to reduce harms associated with opioid use disorder (OUD), with untreated OUD manifesting recently as overdose deaths. OAT is proven to be safe and cost-effective, with other benefits that include¹:

- *Increased retention in treatment*
- *Reduced illicit opioid use*
- *Reduced criminal behaviour*
- *Decreased injection drug use and lower risk of hepatitis C and HIV transmission*
- *Reduced nonfatal and fatal overdoses*

There are currently two OAT medications covered as regular benefits under BC PharmaCare, methadone and buprenorphine/naloxone (e.g., Suboxone®). In all Canadian provinces, physicians must hold an exemption under section 56 of the Controlled Drugs and Substances Act to prescribe methadone. However, the federal S56 requirement for methadone prescribing has no sound scientific basis and remains a barrier to treatment. Currently, in BC, physicians must also hold a methadone exemption before they can prescribe buprenorphine/naloxone (bup/nx). This is not true for all provinces (e.g., Alberta, Ontario, Quebec, Nova Scotia, PEI). It is expected that restrictions on bup/nx prescribers will be eliminated in coming months, allowing all BC physicians to prescribe and improving access through primary care.

BACKGROUND

Research has demonstrated that maintenance OAT significantly reduces mortality, with a recent meta-analysis reporting that *overdose-related mortality rates are 3.5 times higher among individuals with untreated OUD* compared to those retained in maintenance OAT.² Although both agonist medications are similarly effective in terms of treatment outcomes,¹ bup/nx-based OAT has several key advantages over methadone that allow for focusing efforts on improving access to addiction treatment through all primary care offices throughout the province as an overdose prevention strategy. These advantages include fewer side effects, more flexible dosing schedules compared to methadone, lower risk of interactions with alcohol and other medications, lower risk of diversion, and a four- to six-fold lower risk of unintentional overdose versus methadone.^{3,4} *Recent studies have implicated methadone in up to 25% of prescription opioid overdoses in BC.*⁵ Although bup/nx has been available in BC since 2010, it remains underutilized, with nearly twice as many individuals starting methadone versus bup/nx-based OAT according to the most recent estimates (2014).⁶ Other jurisdictions, such as the US and France, have capitalized on these advantages to address the global opioid crisis, rapidly *mobilizing bup/nx-based OAT through low-barrier primary care delivery models.*

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In the US, increased uptake of bup/nx in primary care has subsequently been associated with *public health benefits, including: reductions in opioid-related overdose deaths; decreased illicit opioid and other drug use; and decreased HIV risks.*⁷ Similarly, in France, where 20% of all practicing physicians currently prescribe bup/nx-based OAT, adoption of a low-barrier primary care model has contributed to *a decline in opioid-related overdose deaths of approximately 80% since 1995.*⁸

BARRIERS AND OPPORTUNITIES

Traditional barriers to OAT access include a lack of skilled addiction care providers and evidence-based clinical practice guidelines and treatment pathways. In addition, fewer than 300 BC physicians are authorized to prescribe OAT on an ongoing basis, and approximately 50% of these are located within the Vancouver Coastal Health region.⁶ Prescribing capacity in other parts of the province, especially rural and remote regions, is widely recognized as a barrier to accessing OAT. The lack of independent prescribers in primary care has led to an overreliance on private for-profit clinics that exclusively provide OAT to meet increasing demands for treatment. These clinics typically do not provide primary health care, and often charge monthly fees (and additional fees for bup/nx inductions), creating additional barriers for many individuals. Restrictions on OAT, particularly mandatory daily witnessed ingestion, limited provision of take-home doses, and stigma associated with attending methadone clinics and pharmacies have also been identified as deterrents to seeking and/or staying in maintenance treatment.⁹⁻¹¹

What needs to be done

1. Remove prescriber restrictions on both bup/nx and methadone, and focus efforts on enhancing bup/nx-based OAT in primary care and community-based settings;
2. Enhance addiction medicine education and training for all health care providers, including allied health professionals and front-line workers;
3. Disseminate and implement evidence-based clinical practice guidelines and treatment pathways;
4. Evaluate alternate care models for OAT, including:
 - a. Create a provincial information line to access OAT referral, treatment and support;
 - b. Develop a comprehensive Provincial Addiction Treatment Telehealth program to improve access to OAT in rural and remote areas;
 - c. Expand, enhance and improve advertising for the existing RACE Line (Rapid Access to Consultative Expertise) to provide support for existing and new OAT prescribers;
 - d. Develop a stepped care model with treatment intensity and ancillary services matched to individual patient need and preferences, allowing for transitions that benefit participants (flexibility, patient-oriented care) and prescribers (caseload adjustments), including:
 - i. Rapid Access clinics to expedite access to specialized addiction care.
 - ii. Low-threshold clinics that allow harm reduction rather than only abstinence.
 - iii. Providing injectable OAT options (such as diacetylmorphine and hydromorphone) where indicated for patients who do not respond well to standard treatment.
5. Consider revisions to MSP compensation schedules for OAT to provide incentive and increase the province's pool of prescribers in general primary care offices rather than specialty clinics;

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6. Revise prescribing and dispensation regulations for bup/nx to remove mandatory two-month period of daily witnessed ingestion in line with safety evidence;
7. Eliminate patient fees, including “clinic fees” charged at private for-profit OAT clinics;
8. Evaluate feasibility of providing OAT at no cost to all patients, modeled after proven success of the Drug Treatment Program in engaging and retaining individuals in HIV/AIDS treatment, potentially generating population level benefits and cost savings; and
9. Increase surveillance and enact more rigorous oversight of the provision of OAT at individual pharmacies to improve accountability and ensure consistency with evidence-based guidelines.

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9. INJECTABLE OPIOIDS AS TREATMENT

Prepared by: Eugenia Oviedo-Joekes, PhD, Associate professor, School of Population and Public Health, UBC; Scott MacDonald, MD, Physician Lead at Crosstown Clinic, Providence Health Care and Kurt Lock, Outreach coordinator for the SALOME study.

Medically prescribed injectable opioids in supervised settings reach and treat people with severe opioid use, preventing fatal overdoses.

BACKGROUND

Substitution treatment with long-acting oral opioids (e.g. methadone, buprenorphine) is effective at reducing the use of street opioids, and many of the harms associated with their use. However, there is an important vulnerable minority (a subgroup of 15 to 25%) that is either not retained in other treatments for very long or continue to use illicit opioids while in treatment. For these individuals, studies in Europe and Canada showed that supervised medically prescribed injectable diacetylmorphine (the active ingredient in heroin), is an effective and cost effective treatment alternative. The hypothesis is that by providing medically prescribed pharmaceutical-grade heroin at prescribed dosages in sterile conditions in clinical settings, opioid-dependent individuals who cannot stop injecting despite other options available will: (1) be better engaged into and retained in treatment; (2) be protected from harms such as overdose, HIV and hepatitis C infection; (3) be removed from destructive cycles of crime, prostitution, etc. that are often required to acquire the drugs in the streets; and (4) benefit from prolonged exposure to medical and psycho-social support services.

Supervised, medically prescribed diacetylmorphine is now being used with success in a number of countries in Europe (e.g., Germany, the Netherlands, Switzerland, Denmark), where it accounts for approximately 5% to 8% of all those enrolled in substitution treatments. However, there are many countries around the world where diacetylmorphine is not available due to regulatory and/or political reasons. To overcome this barrier, a recent study conducted in Vancouver, Canada, tested if hydromorphone, a licensed opioid, was as good as diacetylmorphine at reducing street opioid use and retaining patients in treatment. The SALOME study, a double-blinded non-inferiority randomized controlled trial demonstrated that injectable hydromorphone is as effective as injectable diacetylmorphine for long-term injection street opioid users not currently benefitting from available treatments. Both medications, delivered in identical conditions, have proven to have positive outcomes such as high retention rates (80%), reduction of street drug use (from daily to few days per month), and illicit activities. Thus, in jurisdictions where diacetylmorphine is currently not available, or in patients where it is contraindicated or unsuccessful, hydromorphone provides a licensed alternative.

In the Supervised Model of Care of medically prescribed injectable opioids ensures safety for the patients by, for example, providing pharmaceutical-grade, unadulterated, injectable opioids in known doses and onsite treatment of overdoses and seizures. It also ensures the safety of the community (i.e., prevent

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diversion of a strong opioid) and most importantly ensures comprehensive care (e.g., support with securing housing, treating chronic illnesses, etc.), since patients come daily.

BARRIERS AND OPPORTUNITIES

Any Health Authority that has a community clinic or harm reduction service that opens daily, can hold opioids, has a Registered Nurse (RN) and an area where people can inject under the RN supervision, could provide medically prescribed injectable hydromorphone (and diacetylmorphine when available).

Important steps for moving forward:

1) Hydromorphone coverage needs to be expanded in the provincial drug formulary

Lead responsibility: Ministry of Health (MoH). Hydromorphone solution 50mg/mL coverage needs to be expanded for physicians to prescribe at the doses required for these patients. Currently we can prescribe every 35 days the quantity our patients use in half a week. Later, coverage needs to be expanded to the 100mg/mL and diacetylmorphine when available.

2) Build capacity to treat people that remain untreated

Data from recruitment into SALOME indicates that currently 500 individuals in Vancouver need this treatment. A total of 140 are being treated at Providence Health Care's Crosstown Clinic in the Downtown East Side. There are 16,527 patients receiving methadone for maintenance treatment in British Columbia (from PharmaNet data). Based on European studies, less than 10% of all patients accessing substitution treatment would require treatment with medically supervised injectable opioids.

Lead responsibility: Building capacity is the responsibility of each Health Authority (HA), with the support of the MoH. As such, each HA will have individual challenges and opportunities to consider.

The benefits of the supervised model of care begin by meeting people where they are at. From there, health providers can build on the therapeutic relationships through the daily visits while keeping them safe from harms associated with street opioid use. There is flexibility and adaptability for scaling up IOT in diverse settings, and the tremendous possibilities associated with it. For example, it could expand through existing Harm Reduction initiatives (e.g., supervised injection sites), Public Health approaches (alongside Insite), or through primary care and substance use disorder clinics (community clinics). A community clinic could receive weekly individually-labelled syringes with the medication (as many do now for oral methadone) and keep them in a locked fridge. Access to comprehensive care need to be made available with IOT for optimal treatment effect and for cost-effectiveness. However, it is important that the care offered responds to the needs, culture and context of the patients treated.

3) Training

Currently only the study investigators and the clinical team at PHC Crosstown Clinic are trained to prescribe, deliver and monitor this treatment. To build capacity it is imperative to train physicians and allied health care providers.

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10. INPATIENT WITHDRAWAL MANAGEMENT AND RESIDENTIAL TREATMENT

Prepared by: Christy Sutherland MD CCFP DABAM, Medical Director PHS Community Services Society; Cheyenne Johnson RN MPH CCRP, Urban Health Research Initiative; Vera Horsman LPN, PHS Community Services Society

Inpatient withdrawal management (i.e. detoxification) and residential treatment have historically often been first line options for the treatment of opioid use disorder. Acute withdrawal management (i.e. detox) provides short stays in a medically supervised environment, where nurses and physicians closely monitor the acute phases of withdrawal. Residential treatment provides a longer stay in a group environment. Residential treatment provides safe accommodation, meals, and usually incorporates psychosocial treatment interventions such as counselling and therapy.

BACKGROUND

As strongly recommended by the VCH Opioid Addiction Guidelines, withdrawal management alone is no longer recommended as a stand-alone treatment modality for opioid use disorder. Relapse is common in patients who receive withdrawal management alone. Due to reduced opioid tolerance after a period of abstinence, they are at high risk for fatal and non-fatal overdose¹ if withdrawal management is the only intervention provided (i.e. without transition to long-term treatment). Additionally, relapse often involves higher HIV risk behaviour such as needle sharing, and this results in the increased HIV seroconversion after a short-term opioid agonist taper². In general, opioid withdrawal does not require acute care utilization and can be safely managed on an outpatient basis with medical supervision. It is important that both inpatient and outpatient withdrawal management serves as a connection to long-term care and follow up rather than be viewed as a stand-alone treatment modality.

In BC, there are a variety of residential programs that span the treatment continuum however, there are no standardized regulations for inpatient residential treatment in British Columbia. Many programs have abstinence-based focus and do not offer maintenance treatment with methadone or buprenorphine/naloxone (Suboxone®). This abstinence approach often extends to psychiatric medications, and may involve encouraging patients to taper their medications. In addition, there is an absence of high level evidence that supports residential treatment as an effective treatment modality for opioid use disorder³. Canadian data is limited, however one study in the US indicated that relapse is relatively common, with 80% relapse within one month of treatment, 59% within a week of discharge⁴. Residential treatment is largely under-studied and the studies that do exist report varied treatment outcomes. More research is needed to determine target patient populations and treatment outcomes associated with residential treatment for opioid use.

BARRIERS AND OPPORTUNITIES

Withdrawal Management:

- There are often wait lists of 10-14 days for medical withdrawal management facilities in BC.

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- Patients in remote and rural areas often have to travel long distances to urban centres.
- The majority of opioid use disorder patients can be safely managed on an outpatient basis and do not require acute withdrawal management
- There is a lack of evidence-based withdrawal management pathways and treatment guidelines.
- The majority of medical withdrawal management services are still providing harmful, short-term tapers, without connecting to long-term supportive treatment.
- Vancouver Coastal Health has launched a new home-based withdrawal management program that connects people with ongoing care and resources.

Residential treatment:

- The American Board of Addiction Medicine (ASAM) has developed placement criteria for predicting intensity of care required for adolescents and adults.⁵ These criteria are not widely used in BC.
- Each residential treatment program has its own unique application and intake process, which is difficult for health care providers and families to navigate.
- Overall, there is limited evidence-based addiction medicine knowledge by physicians, allied health and counsellors across BC.
- There are only two provincially funded tertiary inpatient residential treatment facilities in BC for target populations (Burnaby Centre for Mental Health and Addictions and Heartwood Centre for Women). The remaining treatment centers are often private pay and are cost prohibitive to patients not on disability or without private medical coverage
- Residential treatment is an important entry to treatment to facilitate patient autonomy around treatment goals and for patients who have safety sensitive positions and whose unions or governing bodies do not allow opioid agonist treatments to return to work (i.e. pilots, oil and gas industry)

People who use opioids would benefit from increased access to addictions treatment, including rapid intakes to medical detox, and methadone and buprenorphine/naloxone maintenance rather than short tapers. They would also benefit from an increase in the continuity of care between treatment providers. People who use opioids would benefit from attending inpatient detox if they have medical comorbidities that make outpatient detox unsafe, as well as to engage in rapid methadone and suboxone starts, or complex methadone to suboxone transitions.

Additional high-quality research is needed to continue to assess the role of residential treatment for patients with opioid use disorder; however, short-term withdrawal management strategies only have been demonstrated to cause significant morbidity and mortality

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People who use opioids would benefit from:

1. Standardizing medical care in withdrawal management and residential treatment facilities (i.e. evidence based guidelines)
2. Regulating residential treatment facilities
3. Improving access to long-term treatment and follow up
4. Increasing access to opioid agonist treatment in primary care settings
5. Creating a centralized intake/referral system to improve system navigation for community health care providers
6. Increasing evidence-based addiction medicine training for all providers
7. Increase availability of acute withdrawal management beds and outpatient management programs - decrease wait times, facilitate access rural/remote areas etc.
8. Provision of culturally safe, trauma informed care

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11. CO-OCCURRING MENTAL HEALTH & SUBSTANCE USE DISORDERS

Prepared by: Naomi Dove, MD MPH FRCPC, Public Health Physician, BC Centre for Disease Control

Mental health and substance use disorders commonly occur together and are associated with worse prognosis and adverse outcomes, including opioid overdoses. Early detection and intervention, enhanced prevention and the integration of mental health, addictions treatment and harm reduction services are key components of a multi-faceted overdose response strategy.

BACKGROUND

Co-occurring mental health and substance use disorders represent a significant health burden and contribute to overdose deaths. Of 182 overdose deaths of youths and young adults investigated by the BC Coroner's Child Death Review Panel between 2009-2013, over one third had a mental health diagnoses at time of death, one third a prior overdose hospitalization and over 90% a past drug and alcohol use history, highlighting missed opportunities for detection, early intervention and prevention. National survey data indicates a 12-month prevalence of 1.7% for co-occurring disorders, peaking in the 15-24yr age range. Approximately 20% of individuals with a mental illness had a history of substance use issues in the past year, a rate 2x greater than the general population, while ~15% of individuals with substance use had a past year history of mental illness, approximately 3x higher than the general population. Large international population studies have observed elevated lifetime estimates - over 30% of individuals with a mental illness had a substance use disorder at some point during their lifetime, while over 50% of individuals with a substance use disorder (other than alcohol) had a lifetime history of mental disorder, with approximately 4% exhibiting opioid use disorder. Individuals with severe psychiatric disorders such as bipolar and schizophrenia were particularly at risk, with substance use disorder rates 6x and 11x higher, respectively, than the general population, associated with increased illness severity, worse prognosis and increased mortality rates. Canadian prevalence is likely underestimated in survey data due to lack of inclusion of key psychiatric disorders, exclusion of key populations (eg. on-reserve communities, correctional institutions, individuals not accessible by landline telephones) and lack of assessment of lifetime prevalence.

The impact and treatment of concurrent disorders vary according to the type and severity of mental illness and substance used. Social and environmental risk factors including early adversity, poverty and trauma, shared genetic predisposition and biological and psychological impacts of existing illness/substance use increasing susceptibility to subsequent disorders are theories why mental illness and substance use co-occur. Overall, co-occurring disorders are associated with a more challenging course of illness and poorer prognosis, less responsiveness to treatment options and increased risk of adverse outcomes, including overdose and death. A retrospective UK analysis involving ~4500 individuals with opioid use disorder observed suicidality was associated with a 2-fold increase of overdose mortality among individuals who did not receive mental health services. While links between overdose, suicide and intent are complex, these findings underscore importance of timely and effective mental health screening and referral.

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BARRIERS AND OPPORTUNITIES

Reducing risk factors and enhancing protective factors along the life course to promote the well-being of individuals and families, and addressing social and structural determinants of health that contribute to health inequities, are critical aspects of prevention. Increasing screening and early detection of mental health and substance use disorders through primary and specialized care, expanding access to evidence based addiction treatment and integrating harm reduction activities are key strategies to address adverse impacts associated with co-occurring disorders. Mental health and substance use disorders are highly stigmatized, frequently occurring in the context of marginalization and social exclusion, impacting access and quality of care. Historical challenges including complexity navigating disparate mental health and addictions treatment systems, lack of integration with public health and lack of specialized capacity to treat disorders simultaneously highlight the need for integrated approaches between mental health, addictions, primary care and public health.

Key areas for action:

1. Education
 - a. Increase access to education for front line providers to enhance awareness and increase utilization of effective screening tools for mental health and substance use disorders
 - b. Expand access to evidence based addictions medicine training for all providers, including access to opioid substitution therapy training²
 - c. Enhance access to specialized training for co-occurring disorder treatment and prevention³
2. Harm reduction
 - a. Increase access to full spectrum of harm reduction services for mentally ill and substance using populations, including expanding outreach services
 - b. Facilitate training for front line health providers to build skills in harm reduction and trauma informed practice, address stigma and enhance cultural awareness⁴
3. Program, service and system integration
 - a. Establish integrated, low barrier multi-disciplinary programs incorporating primary care, mental health, addictions and public health service delivery⁵
 - b. Formalize inter-disciplinary referral & consultation networks at local and regional levels
 - c. Increase interdisciplinary collaboration at the leadership level, leveraging existing provincial tables in harm reduction, addictions and mental health, or through the creation of new forums, to address collective priorities⁶

² Example: St. Paul's Clinical Addictions Medicine Training Program

³ Example: CAMH Concurrent Disorders Certificate Program

⁴ Example: Compassion, Inclusion and Engagement training initiative

⁵ Example: BC Integrated Youth Service Initiative

⁶ Example: Network for Excellence in Substance Dependence and Related Harms; BC Harm Reduction Strategies & Services

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4. Data Collection
 - a. Collate current surveillance data on the burden of co-occurring disorders in BC and relationship to opioid overdose events to inform intervention and prevention activities
5. Prevention
 - a. Facilitate meaningful opportunities for inter-sectoral action to address underlying social determinants contributing to health inequities for populations with co-occurring disorders

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12. PRESCRIPTION OPIOIDS

Prepared by: Kate Smolina, PhD, BC Observatory for Population and Public Health, BCCDC and Postdoctoral Fellow, School of Population and Public Health, University of British Columbia

Understanding the pharmacoepidemiology of pharmaceutical opioid (PO) use in BC as an important upstream context to the current public health emergency of opioid overdose fatalities. In the summary below, PO is understood to mean any opioid drug that is eligible to be prescribed and excludes heroin; both prescribed and illicitly obtained PO drugs are captured.

BACKGROUND

“It is critically important that the opioid epidemic is understood as much greater than an epidemic of mortality – it is also an epidemic of dependence, addiction, disability, and other severe adverse events affecting millions of people.”

Franklin et al. AJP 2015; 105(3):463-69.

Thousands of opioid prescriptions are written every year in BC, with consumption levels increasing by 31% between 2004 and 2013. Some patients who receive these medications will subsequently develop dependence and addiction, while others will seek prescriptions for entirely non-medical uses. Use of opioids has been found to be associated with fractures, road trauma, emergency department visits and both intentional and unintentional toxicity deaths, with a strong dose-response relationship. In Ontario and US, dramatic increases in prescription opioid use in recent years have been accompanied by increases in opioid-related overdoses and deaths.

Unfortunately it took many years for the increases in opioid use and opioid-related harms to be noticed and acted upon in Canada because there are no national and limited provincial monitoring and surveillance systems for prescription drugs. The fentanyl overdoses crisis in BC presents an opportunity to plan and test approaches to collecting, analyzing, and acting upon information concerning the use of opioids – and, importantly, other medicines – to deal with the current situation but also to prepare for and prevent future emergencies.

PO consumption in BC

Increased opioid consumption (in terms of morphine equivalents, ME) in BC has been driven by longer durations of opioid therapies and by an increase in the use of stronger opioids, and not by increase in the users filling at least one opioid prescription (~12% total or ~15% 25 years and older population). Consumption has been increasing for oxycodone, hydromorphone, fentanyl, and tramadol; and declining for morphine, codeine, and other opioids. There are no large sex and age differences but consumption is three times as high among individuals in the lowest income quintile compared to those in the highest quintile. High levels of opioid consumption lead to higher availability of opioids among the general population, thus increasing opportunities for harms, diversion and problematic use.

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PO-related mortality in BC

Unlike trends in PO consumption, rates of PO-related death⁷ in BC are relatively high, but they did not increase from 2004 to 2013 (~3.9 deaths per 100,000 population per year). Despite the stable overall rates, deaths involving both prescription opioids and benzodiazepines increased steadily, rising from 2% of PO-related deaths in 2004 to 14% in 2013. One in four PO deaths are due to overdose on methadone alone. Men experienced higher mortality rates than women, at almost double the rate, thus accounting for approximately two-thirds of all PO-related deaths in BC. The sex difference in mortality contrasts that in consumption.

Relationship between PO consumption and mortality

There is significant geographic variation in rates of PO consumption and PO-related death. Analysis of small-area variations yields a positive association between dispensations and unintentional deaths. On average, regions with higher rates of opioid prescribing also have higher rates of PO-related death.

However, there is a twist: while users of POs tend to be middle-aged men and women, PO-related deaths are highly skewed towards younger men. Further, half of women and two thirds of men who suffer a PO-related death do not have an active or recent opioid prescription.

The findings above suggest that a) level of opioid consumption is only one explanatory factor for opioid-related mortality; b) diversion plays a big role in the supply of opioids that eventually contribute to accidental overdose deaths; and c) men are more likely than women to obtain POs that were not prescribed to them and to subsequently overdose on them.

Long-term users of POs

Overall, about 2% of all individuals who are given their first-ever opioid prescription will go on to become a long-term user within a year; about 5% will get there within five years. However, the risks increase with age, with as many as one in ten individuals aged 65 years and older becoming a long-term user within a year of receiving the initial prescription.

There is a growing prevalent population of long-term PO users⁸ in BC, with new long-term users emerging every year at a stable rate. In 2012, about 100,000 BC residents, or 2.4% of total population (3.3% of those 25 years and over), were long-term PO users. The majority of them were prevalent users who accounted for most of the opioid consumption in the province. Most long-term users had one continuous episode of use spanning multiple years. Almost two thirds took opioids every other day or more frequently. The top 25% of every day users received a dose of 200 ME or higher per day, suggesting either extremely high tolerance or diversion in this patient group.

⁷ PO-related death was defined as a vital statistics death record where the primary cause of death is equivalent to drug poisoning and a prescription opioid listed as one of the contributing causes of death. Source of drug is not recorded.

⁸ To be classified as a long-term opioid user, a patient had to fill one or more prescriptions containing at least 90 days of opioid therapy, with no gaps in prescriptions lasting longer than six months. Cancer and palliative patients were excluded.

Transition to illicit drug use

The understanding of the trajectory from prescribed opioid use to illicit opioid use is not comprehensive. We know that those who use POs for non-medical purposes are much more likely to become heroin users than those who don't use POs non-medically. Equally, studies consistently show that the majority of heroin users report prior non-medical use of prescription opioids. Nevertheless, transition to heroin use among non-medical opioid users is generally rare.

However, there are numerous knowledge gaps around the nature of the transition from medical use of POs to non-medical use. The 2012 data from the Canadian Alcohol and Other Drug Use Monitoring Survey show that 5% of opioid users aged 15 years and older reported using them for reasons other than pain relief. Yet we do not have a comprehensive understanding of the physiological, biological, psychological, and other pathways that lead from opioid use for pain to non-medical use. We also do not know all the routes involved in sourcing opioids for non-medical use. The extent of diversion is difficult to characterize: sources of POs vary and include family/friends, pharmaceutical fraud, street markets, and pharmacy thefts. The numerous routes make it very difficult to measure, track, and intervene.

BARRIERS AND OPPORTUNITIES

Addressing problematic use of pharmaceutical opioids in BC will require a multi-faceted, multi-stakeholder approach. Integration with already existing programs and strategies is key for success. A recent literature review of state- and system-level interventions in the US and Canada found that promising strategies are the ones that reduce inappropriate prescribing and use of multiple providers, and focus on overdose response. Such strategies include prescription drug monitoring and surveillance, education of patients and providers, pain clinics, clinical guidelines, and naloxone distribution programs.

In BC, a response to the opioid crisis could be deployed in the following parallel streams: monitoring and surveillance; education and prevention; treatment and harm reduction; and regulation and enforcement. Examples of specific actions include:

- Better information sharing and use among multiple stakeholders, especially for prescription and illicit drug monitoring and surveillance
- Targeted training and education of healthcare professionals, especially high prescribers
- Adoption of new CDC guidelines as the standard of practice, which introduce new and lower watchful doses and recommendations for initiation of opioid therapy
- Increase public awareness of risks of opioid therapy, particularly among the high-risk groups
- Prevention of overdose fatalities through harm reduction mechanisms (e.g. naloxone, safe injection sites)
- Coordinated, accessible, and affordable system for treatment of pain and addiction
- Clear standards against which practitioners will be judged for regulation/enforcement of quality assurance in clinical practice

Barriers to implementation of the above actions are numerous but not out of reach. Some key opportunities for immediate action are briefly described below. Overall, there is a need for a coherent provincial approach with a clear leadership and direction to ensure sustained collaboration among multiple stakeholders.

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- Despite having some existing infrastructure for monitoring and surveillance of PO-related use and harms, none of the various data sources are currently linked or integrated in a systematic and ongoing way to enable routine gathering of comprehensive information.
- Existing partnerships such as the Drug Overdose Alert Partnership and the Prescription Review Program at the College of Physicians and Surgeons of BC could be more effective if access to PharmaNet and other healthcare data sets was enabled and analytic capacity increased.
- The PharmaNet database is greatly underutilized. However, to fully realize its potential as an invaluable tool to support both clinical management and public health surveillance functions, PharmaNet needs to be made more accessible and more user-friendly in everyday clinical context. Specifically:
 - Provide PharmaNet set up and access free of charge to prescribers
 - Drop the requirement for patient consent for PharmaNet access
 - Provide prescriber profiles and/or peer comparison reports, adjusting for patient comorbidities
 - Expedite the rollout of e-prescribing functionality
 - Introduce built-in prescribing support mechanisms for opioids, including flags/warning that indicate both potentially problematic prescription as well as potentially problematic pattern of use on behalf of the patient
 - Redevelop PharmaNet interface, making it easy and efficient to use for quick referencing
 - Develop an ongoing prescription drug monitoring and surveillance program based on real-time PharmaNet data feed
- Developing and/or expanding treatment services for pain and addiction requires a substantial investment of new resources.
- Develop effective mechanisms to ensure that targeted prescriber education efforts lead to full participation and subsequent adherence to best clinical practice.

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Presented by:

13. PUBLIC HEALTH BASED OPIOID MANAGEMENT AND REGULATION

Prepared by: Mark Haden, PhD, Adjunct Professor, UBC School of Population and Public Health and Brian Emerson, MD, Medical Consultant, BC Ministry Of Health

Our current approach to the management and regulation of opioids is resulting in a significant mortality and morbidity. Therefore a new approach is needed which addresses opioid supply and harms, and out-competes the illegal market by providing people who use opioids with products of known concentration and high quality in a variety of settings, which includes supervision.

BACKGROUND

The management of opioids relies on prohibition or a prescription process which has been influenced by commercial interests. Both have exacerbated rather than mitigated problematic outcomes. The persistent demand for opioids is met by either supply from an illegal, unregulated market; or from a prescription based market that relies on existence of a medical condition and self-regulated, skilled practitioners to supply opioids in accordance with best practices.

Prohibition of opioids has had limited impact on supply and causes significant unintended consequences, including the creation of an illegal market controlled by violent organized criminal enterprises that produce concentrated and contaminated products. The pharmaceutical industry/private practitioner driven market is also problematic in that it has produced an epidemic of opioid use disorders, overdoses and deaths. The overlap between these markets is substantial as some opioid prescribed patients subsequently switch to the illegal market, and vice versa.

Given these failures and harms, it is time to rethink opioid management and regulation from a public health perspective. This means employing public health principles and strategies, re-balancing to address demand through more holistic, non-pharmaceutical pain prevention and management strategies, and implementing a new approach to addressing opioids supply which out-competes the illegal market by providing people who use opioids with products of known concentration and high quality in controlled settings as follows:

Control Structure: A dedicated control body would manage and regulate all opioid related activities (e.g. importation, large scale poppy growing, production, distribution, prescription and retailing) as well as engage with the pain management system to ensure that opioids are skilfully used. The control body mandate would be explicitly guided by a public health oriented vision, principles, goals and objectives.

Medical Access: Prescribers and dispensers, overseen by the control body, will supply a wide range of opioids (e.g. morphine, hydromorphone, methadone, buprenorphine, heroin, etc.) for pain management and other conditions as well as offering these same opioids for treatment of opioid use disorders. Integral to this would be development of non-pharmaceutical pain management programs. Restrictions would be placed on the pharmaceutical industries promotion of these products.

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Non-medical Use Access: As prohibition has failed, a method of legal access for adults needs to be formulated. Therefore, adults who want to consume opioids for non-medical use could do so in a system which would involve either a basic or an advanced purchase licence. To obtain a basic licence an individual would participate in training which would include information about the drug effects and risks, safe use, problematic use and treatment and recovery, and overdose prevention and treatment. Participants would then be registered in a data base for tracking of purchase and consumption patterns. Risky use would be flagged for assessment. With a basic licence, individuals could purchase either weak opioid products for oral or inhaled use at home such as poppy seeds, dried poppy pods and stems, poppy tea and weak opium i.e. less than 12% morphine. A basic licence holder could also purchase concentrated products (e.g. pure oral, injectable or smokable opioids including heroin) to consume at the place of purchase, under the supervision of a health care professional, where primary health care and counselling services would be available.

An individual who wanted to use concentrated opioids for non-medical purposes at home would need to graduate to an advanced licence by meeting a number of criteria such as possession of a basic licence for 2 years without criminal involvement, no convictions for driving while impaired, have a stable life (e.g. stable housing, be employed, regularly volunteer, or be a student), be assessed for problematic use; and be able to identify at least one person who will be with them when they are using the product.

Non-medical Use Availability, Accessibility, Purchase, Consumption, and Use Controls: Opioids would only be sold at regulated retail outlets, including existing pharmacies, to people at least 19 years of age. Retailers would be certified in basic pain management and opioid dispensing, and emergency overdose treatment. There would be rules on purchase quantities. Rules against public smoking of opioids and opioid impaired driving would be enforced.

Supply control: Products would be subject to standard consumer protection quality assurance and manufacturing processes. Labelling would include details about the ingredients, concentration, use instructions and have prominent warnings. People would be allowed to grow their own poppies and home-make products for their personal consumption, but would not be allowed to provide home-made products to others.

Demand reduction: Factual information and health promotion material on benefits and harms would be required to be made by producers and would be prominently displayed and available from retailers. Health information about pain therapy options and other symptom treatment would be available, including alternative and complementary pain management information. All product promotion such as branding, advertising, product placement, celebrity endorsement and sponsorship would be banned, as would all product promotion to health care professionals.

BARRIERS AND OPPORTUNITIES

Resistance can be anticipated from the pharmaceutical industry, established health care professions, as well as the general public who may view these ideas as promoting widespread opioid use. However, as stated by the Senate Special Committee on Illegal Drugs “This approach is neither one of total abdication nor an indication of abandonment but rather a vision of the role of the State and criminal law as developing and promoting but not controlling human action, and as stipulating only necessary prohibitions relating to the fundamental principle of respect for life, other persons, and harmonious community, and as supporting and assisting others, not judging and condemning difference.”⁹

Given the emergency nature of the current situation with such severe consequences, and indications of worsening rather than improving, this model could be urgently explored for BC implementation as a medical, scientific and public interest project through a *Controlled Drugs and Substances* section 56 exemption process.

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See also “Amazon, but for deadly drugs: Why fentanyl and W-18 are here to stay” for detailed description of how the illegal market operates to understand the rationale for adopting a public health approach that out-competes rather than tries to suppress the illegal market. <http://vancouversun.com/news/local-news/0530-amazon-but-for-deadly-drugs-why-fentanyl-and-w-18-are-here-to-stay>

⁹ Nolin P. Cannabis: Our Position for a Canadian Public Policy – Report of the Senate Special Committee on Illegal Drugs. Ottawa: Senate of Canada; 2002

14. DRUG POLICY AND OVERDOSE

Prepared by: Donald MacPherson, Director, Canadian Drug Policy Coalition, Centre for Applied Research in Mental Health and Addictions, Simon Fraser University

Canada's drug policies are in urgent need of review. While the risks related to substance use vary from substance to substance a variety of factors contribute to increasing or decreasing risk of harm for people using illegal drugs. Drug policies are created to protect the public health and safety of all Canadians, including people who use drugs. Given the declaration of a public health emergency related to opioid overdose deaths a significant effort to identify drug policies that are contributing to this situation needs to be a part of the analysis. There is a compelling body of evidence that the current policy of drug prohibition has contributed to significant harm to individuals and communities in Canada and globally in a variety of ways. In light of the opioid overdose emergency a comprehensive review of Canada's approach to drugs should be conducted in the interests of facilitating emergency preparedness, response and overdose prevention.

BACKGROUND

Current drug policies that promote and prolong drug prohibition as the primary policy framework for reducing the harms related to drug use actually create significant risks of overdose for people who use illegal substances. The recent *Johns Hopkins–Lancet Commission on Drug Policy and Health* report found “the pursuit of drug prohibition can contribute to overdose risks in numerous ways. Prohibition creates unregulated illegal markets in which it is impossible to control the presence of adulterants in street drugs, which add to overdose risk. Several studies also link aggressive policing to rushed injection and overdose risk. People with a history of drug use, who are over-represented in prison because of prohibitionist policies, are at extremely high risk of overdose when released from state custody. Lack of ready access to Opioid Substitution Treatment (OST) also contributes to injection of opioids, and bans on supervised injection sites cut off an intervention that has reduced overdose deaths very effectively. Restrictive drug policies also contribute to unnecessary controls on naloxone, a medicine that can reverse opioid overdose very effectively.”

A reorientation of Canada's drug policies based on evidence of what we know works and what doesn't will enable a more robust overdose prevention and response capacity with increased coordination and surveillance at the national level. With funding for the current National Anti-Drug Strategy expiring in 2017 there is an immediate opportunity to engage in the development of new evidence-based approaches in Canada. Countries with moderate to high levels of substance use that have successfully reduced and maintained overdose deaths at lower levels share a number of characteristics in their approaches including: integration of harm reduction policy at all levels of government, a robust array of low threshold harm reduction services targeting high risk populations including supervised consumption services, housing/shelter options that embrace harm reduction, intensive contact with high risk populations, and comprehensive OST programs.

Presented by:

OFFICE OF THE PROVINCIAL HEALTH OFFICER OF BC | BC CENTRE FOR DISEASE CONTROL | BC CORONERS SERVICE

Recommendations for Action on Overdose

1. Accelerate the development of a new drug strategy for Canada based on principles of public health and human rights with a strong focus on overdose prevention and response, including policy options at the federal level that would facilitate and support program innovation and experimentation, enhance surveillance and coordination and provide leadership in research and evaluation.
2. Revise section 56 of the Controlled Drugs and Substances Act to maximize its utility in supporting research and experimentation with different uses for substances covered by the CDSA and facilitating in a timely fashion, the establishment of: heroin assisted treatment, novel treatment approaches including the use of psychedelics, street drug testing, and other innovative responses.
3. Immediately move towards decriminalization of all drugs for personal use with generous limits for possession. Results in the Czech Republic and Portugal where drugs have been decriminalized for a number of years (since 2001 in Portugal and Czech Republic 2010) have been positive across a number of key metrics including overdose prevention. Stop criminalizing people who use drugs. Implementing a public health approach to drugs while criminalizing those individuals that are the focus of public health efforts is counter-productive.
4. Consider experimenting with regulated access to low dose opioids for non-medical use accompanied by education on responsible opioid use, as an interim strategy to divert people who use opioids from the extremely dangerous illegal market. Prioritize access to safe opioids for people with opioid substance use disorders in the context of treatment or outside of treatment but within a harm reduction framework.

BARRIERS AND OPPORTUNITIES

1. Leadership at all levels of government - political and bureaucratic. New approaches to drug policy are often poorly understood, or counter-intuitive such as, treating heroin addiction with heroin, and therefore are often contentious. Political leadership is necessary to accelerate public understanding of concepts and the need for implementation.
2. Legislation, Regulations and Policy. Modernizing Canada's legislative, regulatory and policy frameworks was identified by Health Canada in 2005 as a key priority in Canada's national framework for action. Little work has proceeded on this priority to date.

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15. DRUG ENFORCEMENT

Prepared by: Deputy Chief Michael Serr, Abbotsford Police Department

Drug enforcement must continue to play a key role in any effort to disrupt the unprecedented increase in overdose deaths. Law enforcement efforts must be strategic and intelligence led to ensure our efforts are directed to enforcement strategies that will have the greatest impact. Focused enforcement on importation, production and distribution must be our priority. Public health officials are best positioned to address public health and addiction issues, thereby allowing law enforcement to concentrate our efforts on the more serious drug offences. Additionally, law enforcement needs to strongly advocate for legislative changes to keep current with the emerging trends and provide us with the tools to effectively address our enforcement strategies.

Finally, law enforcement is well positioned to message the public and more importantly youth about the significant dangers related to synthetic opioids and the W-Series. This messaging needs to be done in partnership with public health officials and other stakeholders to ensure the message is balanced.

BACKGROUND

With the emerging trend over the last four years towards synthetic opioids such as Fentanyl and the W-series, law enforcement has had to refocus our enforcement priorities. Targeting those that import, produce, and distribute synthetic opioids must now be our number one priority. These investigations are extremely challenging and costly and often have national and international connections. Unfortunately, law enforcement is often frustrated in our efforts as a result of not having effective tools to disrupt the drug trade. Specifically, it is important that regulations and laws be put in place that makes it more difficult to produce and import precursors and synthetic opioids. As an example:

- Pill presses are unregulated in Canada. These industrial grade pill presses, pill sorters, and dyes are often imported into Canada and law enforcement does not have the tools available to prevent them being used for illicit purposes.
- Many precursors used in the production of synthetic opioids, methamphetamine, etc. are not regulated and law enforcement is unable to take enforcement action prior to them being used in a clandestine lab.
- The diversion of regulated precursors continues to pose a challenge for law enforcement. Drug producers continue to find loop holes in the system and are able to purchase precursors from companies authorized to possess.
- Fentanyl can be easily purchased over the internet and shipped in small amounts via the mail. The interception of these shipments is proving very challenging for law enforcement.
- Small amounts of Fentanyl and the W-Series can produce large quantities of street drugs for sale and as a result there is a very large profit margin. Preventing these drugs from being the drug of choice for organized crime needs to be a priority.

Presented by:

Drug investigations today are resource driven and very expensive. Currently, policing is facing a challenge to maintain current operating budgets and staffing levels. Often, specialty sections like Drug Squad, Youth Squad etc. are the first to be reduced. Additionally, operating investigative budgets are limited and the priority is always public safety. While drug investigations, and in particular Fentanyl and W-Series investigations take a priority, other priority crimes like murder and sexual assault take precedence. While law enforcement wants to disrupt drug offences at the highest level, this is often not feasible and quicker investigations are often required.

It is important that the public is educated on the dangers posed by Fentanyl and the W-Series. Law enforcement has always had the means to get the message out; however, moving forward, it is important that the message is balanced and includes other stakeholders. The “Know Your Source” campaign is a good example of joint partnerships working collaboratively to inform and educate the public. In developing these messaging campaigns we need to move away from the “Say no to drugs” style of messaging to more informative based approaches. This is where our partnerships with public health and other stakeholders are important. The message will resonate better if it comes from all stakeholders on a united front.

BARRIERS AND OPPORTUNITIES

The barriers and key opportunities to move forward with drug enforcement interventions are highlighted below:

- Enforcement – importation and production investigations are very expensive, time consuming and challenging. Many police agencies do not have the resources to effectively initiate and sustain long term investigations. Furthermore, since these investigations can be time consuming other groups continue to operate and gain power as law enforcement focuses on one group.
- Criminal organizations are quick to adapt. Clandestine lab cooks are continually developing new recipes that use unregulated precursors. They are also quick to produce new compounds that do not fall under the *Controlled Drugs and Substances Act*. Additionally, they are finding new avenues to import synthetic opioids in smaller packages into Canada.
- Legislative Change – As we know it takes a considerable amount of time for new laws to be enacted. It also requires well placed stakeholders to be champions for proposed change. As law enforcement waits for these changes to be made or even considered, the problem continues. As an example the following changes are currently being pursued:
 - Bill S-225 from Senator Vern White to have Fentanyl precursors regulated
 - Regulation of pill presses – currently in discussion with Health Canada and Public Safety
 - Request to add additional precursors to the *Controlled Drugs and Substances Act* and *Precursor Control Regulations*. Discussions ongoing.
 - Legislative changes to the *Canada Post Corporation Act* to provide law enforcement with the tools to search in transit mail. Discussions ongoing with Public Safety.

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- Speeding up process to add “New Psychoactive Substances” to the *Controlled Drugs and Substances Act*. Ongoing discussions with Health Canada.
- Messaging – Working collaboratively with partners to develop joint messaging to inform and educate the public with information based approaches is key. Getting all stakeholders together to work collaboratively can be a challenge at times. Furthermore, generating financial resources to develop and promote messaging strategies is not easy and dependant on each stakeholder’s budget.

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Know Your Source? Be Drug Smart - Messaging campaign.
<https://knowyoursource.ca/>

Presented by:

16. CORRECTIONS

Prepared by: Diane Rotheron, MD, Medical Director, BC Corrections

Overdose prevention in provincial correctional centres and after release from custody.

BACKGROUND

Health Care Measures

- Each provincial correctional centre in British Columbia employs a team of health and mental health professionals that closely monitors inmates' health status and responds to their health care needs.
- Upon entry into a correctional centre, all inmates receive an Initial Health Assessment (IHA) within 24 hours of intake. This IHA includes a Clinical Opioid Withdrawal Scale (COWS) and an Alcohol Withdrawal Assessment (CIWA). Inmates also receive mental health screening using the Jail Screening Assessment Tool (JSAT) within 24 hours of intake. The majority of centres have onsite health care staff 16 hours a day, 7 days a week, with procedures in place to transport patients requiring emergency treatment, e.g. overdoses, to an emergency department. Suboxone is used by policy for acute opioid detox.
- Patients who are suitable and have requested to participate in the BC Suboxone or Methadone Maintenance Programs are evaluated according to the criteria outlined in the most recent version of the *Methadone Guideline*, published by the College of Physicians and Surgeons of BC (CPSBC). The absence of opioids in the urine during assessment does not preclude admission to the Opioid Agonist Treatment (OAT) program, if the assessment confirms that OAT is appropriate.
- Once a patient is assessed with a substance-related disorder that requires intervention and/or treatment, a referral is made to the substance use counsellor and, if indicated, the psychologist. If available, the inmate is referred to an appropriate treatment program within the correctional facility or within the Adult Custody Division.
- A substance use assessment includes an evaluation of the inmate's history, current substance use status, treatment needs, risk of relapse, and other needs that may arise. Whenever possible, the addiction counsellor seeks to obtain previous records pertaining to the patient's history of substance use and prior treatment.
- Mental health and substance use assessments focus on obtaining information needed to make decisions about classification and treatment services. Mental health and substance use treatment focuses on restoring the patient's mental and physical health and assisting the patient to receive appropriate services when released to the community. When possible, the services of a forensic liaison, a mental health worker, and/or a community substance use program worker are enlisted to arrange post-release community services.
- Take Home Naloxone (THN) has been implemented in three centres with expansion planned to all centres within a year. Uptake has been high among prisoners in BC.

Correctional Centre Measures

- All inmates are strip searched upon admission to a correctional centre to help prevent the introduction of contraband including weapons and drugs.

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- BC Corrections has strict security measures in place and a zero tolerance policy to deal with contraband in all of its correctional centres, including regular searches of cells, common spaces and program areas to which inmates have access. Searches are authorized by the warden or whenever there are reasonable grounds to believe one or more inmates possess contraband. Cells and rooms are searched prior to occupancy by a new inmate.
- Methadone distribution is followed by inspection of the patient's mouth to ensure swallowing of the entire dose, and then direct observation by correctional staff for a minimum of 20 minutes to reduce the risk of diversion.
- Incidents involving the death of an inmate in custody require a Critical Incident Review (CIR). A CIR is a formal process, initiated by the Assistant Deputy Minister, Corrections Branch, to investigate in a thorough and timely manner, incidents that may have a significant impact on a correctional centre.
- An overdose that does not result in death may prompt a CIR or an Operational Review (OR). An OR is a formal process, initiated by the Provincial Director or the warden of the affected correctional centre to investigate an incident of a serious nature, or a series of events or incidents with common characteristics that might have an impact on a correctional centre or affect operations across the division.

BARRIERS AND OPPORTUNITIES

- Transition from custody to life in the community is extremely challenging. Clients often have no job, family support, savings or a place to live, and may also face mental health and addiction problems. Correctional and medical research indicates the period immediately following release from custody is the highest risk for both criminal recidivism and overdose.
- Health statistics reveal that 60% of correctional clients have a mental health and/or substance use disorder, and many more are undiagnosed.
- Linking released prisoners to community services is extremely challenging. Often, they are not well integrated into community programs due to low literacy, FASD, poor social and coping skills, traumatic brain injuries, ongoing drug use, homelessness and poverty.
- Patients leaving Corrections on OAT are encouraged and assisted in returning to their community prescriber, if available. For patients initiated on OAT while in custody, new community prescribers are difficult to find, especially outside the lower mainland.
- Patients are provided with a 2-4 week discharge prescription of methadone or Suboxone.
- Increasing outreach services to support the transition from incarceration to community will enable continuity of care and better health outcomes.

IMPORTANT REFERENCES

Methadone Guideline, by the College of Physicians and Surgeons of BC (CPSBC) (*provided as additional material*)

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17. THE ROLE OF PEERS

Prepared by: Jane Buxton, MD, Physician Lead for Harm Reduction at BC Centre for Disease Control; Janine Stevenson Harm Reduction Nurse Specialist at First Nations Health Authority; Katie LaCroix, a Peer and Charlene Burmeister, a Peer

Engaging people with drug use experience in policy development, research, programming and practice is necessary to ensure interventions and harm reduction services are relevant and acceptable.

BACKGROUND

A peer can be defined as a person with equal standing in a community who share a common lived experience (Ti et al). Peers are the experts in their own experience and provide important perspectives and a reality check.

Peer engagement uses a community based approach to decision making, as engaging the community in the process is far more likely to lead to effective and acceptable service delivery. However, in practice peers are often underutilized in the prevention of substance use related harms (Marshall et al) and peer engagement efforts involve sharing information only and therefore can be considered merely tokenism.

Alerts and overdose training material should be developed with input from peers to ensure relevance, appropriate language and to avoid unintended consequences. For example, using terms in alerts like potent and strong may lead to drug seeking behaviours (BCCDC). Input from a variety of peer groups is necessary to target affected populations for example street-involved youth, school and university students, people who use drugs in club and party environments and adults with substance use disorders.

Peers should be engaged when developing proposed interventions. A client centred approach should be used. Providing services for people who use drugs is not sufficient to ensure they will be utilized. Peers can identify barriers to accessing health services; for example services must be available (sufficient services wherever people live), accessible (e.g. geographic distribution of opioid agonist therapy in rural areas and supervised consumption services outside Vancouver), accommodating (e.g. low threshold services, opening hours), affordable (e.g. cost of travel, lost work time, payment for methadone clinics) and acceptable (non-stigmatizing services providing trauma informed care).

Peer engagement can address equity of harm reduction services and interventions by fostering communication, building trust, increasing knowledge, and reducing stigma and discrimination to remove barriers and increase utilization of services.

There is a long history in BC of successful peer to peer training such as providing education on overdose, recognition and response including naloxone administration. In Rhode Island, on call Peer Recovery Coaches are paged to meet with a person who has overdosed and to link individuals and their families to treatment and recovery resources and hence taking the burden of emergency department physicians and nurses: <https://providencecenter.org/services/crisis-emergency-care/anchored>.

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BARRIERS AND OPPORTUNITIES

What are the barriers and potential solutions to moving forward?

Service providers may have preconceived ideas about people who use drugs and misperceptions of harm reduction. People accessing services may feel judged during the health care interaction and be reluctant to engage in ongoing care. There is a need for education sessions for service providers about harm reduction, cultural safety and trauma-informed care and moving from a paternalistic health model to a harm reduction model involving peers.

Peers are often paid a token honorarium for attending meetings and providing their expertise, while health authority and other agency professionals attending receive a full salary. Payment should be in cash and commensurate with the time given (“Nothing about us without us”).

Identifying peers in rural regions where there is no ‘User Group’ can be challenging and Peer run organizations or groups should be asked to nominate representatives from their region. However, consultation with service providers and agencies for suggestions can be helpful.

Who has the lead responsibility for this issue?

Health authorities have the lead responsibility through the commitment of senior leadership, medical health officers and managers to support service providers in providing culturally safe, comprehensive and effective prevention and treatment services and to engage peers to make ensure services and interventions are relevant and acceptable.

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18. FIRST NATIONS OFF RESERVE

Prepared by: Leslie Varley, Executive Director, BCAAFC, Warren Clarmont, Senior Policy Analyst, BCAAFC

First Nations Off Reserve: Approximately half of the First Nations population in BC reside off reserve and in BC's towns and cities. This number increases to around 70-75% if Metis and non-status peoples are included. The number of First Nations people leaving their home reserve communities began with amendments to the federal Indian Act in the 1960's, which enabled First Nations people to leave their reserve without written authorization from what was called the Indian Agent at the time. Since then, an urbanization of First Nations people has occurred in BC and across Canada.

BACKGROUND

For Indigenous people, leaving the familiarity of one's home community and moving to a foreign environment comes with a unique set of challenges such as: social isolation, racism, poverty, lack of English literacy, and lack of affordable housing and healthcare. Given these challenges, First Nations people began to establish informal support networks in towns and cities which soon incorporated into societies. These societies became known as Aboriginal Friendship Centres and were established in the late 1950's – early 60's as places of refuge and support for this new demographic, which is now referred to by the federal government as 'urban Aboriginal'. Given the issue of proximity, as well as immediate issues in their home reserve communities, First Nations have not had the capacity to support their citizens living away from home and in urban areas. As such, Aboriginal Friendship Centres have grown to address this gap in support and over the last 50 years, their capacity has grown to:

- 25 Friendship Centres located in most of the major towns and cities across the province;
- Approximately 1000 employees employed throughout those 25 agencies;
- The largest network of Indigenous service providers in BC;
- Over 400 different programs and services delivered by Friendship Centres that span all social sectors such as health, children and families, employment, justice, youth, and education.

In a health services context, only a handful of the 25 Friendship Centres have established, or are seeking to establish health centres and /or clinics that can provide the kinds of supports that are normally only found in a mainstream health clinic or hospital. Some of the current supports include: needle exchanges, HIV/AIDS programs, drug education and awareness programs, patient navigators to link clients to other supports, some communicable disease testing and screening, mental health counselling, and a variety of pre-natal programs and supports.

Friendship Centres are often working with some of the most marginalized individuals, many of whom would be considered to have multiple barriers. Mental health is one of the top barriers facing First Nations people today, and drugs and alcohol are often used as a way to deal with the trauma many of our people face, particularly if they are homeless and living on the streets.

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BARRIERS AND OPPORTUNITIES

The current state of Friendship Centres working with clients who could be at risk of overdose includes:

- Training: Staff in Friendship Centres are being trained in Naloxone administration and education about the treatment;
- Education: using the information currently available, informing clients and staff of Friendship Centres about the risks of hard drug use including the threat of overdose due to Fentanyl;
- Partnerships: working with other health care providers such as the Regional Health Authorities, emergency responders, and other First Nations /Aboriginal communities to educate, create awareness, and provide referrals to other supports that are not offered in Friendship Centres.

Given the emergence of Fentanyl in BC and its associated risks, Aboriginal Friendship Centres are just starting to mobilize and prepare for emergency situations such as an overdose. Friendship Centres are most often delivering programs and supports 'upstream' and in a prevention and early intervention context. Given that Friendship Centres are hubs for services and information to urban Indigenous people, the opportunity exists to disseminate information, undertake training, act as referral bodies, and act as conveners to engage Indigenous people living in urban communities.

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19. ENGAGING FIRST NATIONS IN COMMUNITY AND AWAY FROM HOME

Prepared by: Evan Adams, Chief Medical Officer FNHA; Janine Stevenson, STI/BBI Nursing Coordinator, FNHA and Shannon McDonald, Senior Medical Officer, FNHA

Engaging First Nations communities to ensure harm reduction, substance use and mental health services are effective, accessible, relevant and culturally safe

BACKGROUND

Prior to the establishment of the First Nations Health Authority, the federal government did not formally support harm reduction activities through its mental wellness and substance use programming. As a result there is a wide range/ level of harm reduction services and strategies available in First Nations communities in BC. The transition to the new First Nations Health Authority in October, 2013 marked a shift in providing support and resources for harm reduction services and supplies for First Nations communities in BC.

Guided by the vision of embedding cultural safety and humility into health service delivery, the First Nations Health Authority works to reform the way health care is delivered to BC First Nations through direct services, provincial partnership collaboration, and health systems innovation.

A Path Forward: BC First Nations and Aboriginal People's Mental Wellness and Substance Use - 10 Year Plan was jointly published in 2013 by the First Nations Health Authority, the Province of BC and the Government of Canada as part of the Tripartite First Nations Health Plan commitments. One of its 14 strategic directions is to support initiatives that prevent and reduce the harms associated with substance use in First Nations and Aboriginal communities.

In Community (On Reserve)

- First Nations communities, health centers and residential addictions treatment centres engaged in harm reduction are asking for supplies and support
- Some communities deliver harm reduction services and supports, some do not
- Individuals living in those communities that do not provide harm reduction services and supports must leave the community to access services away from home – this is a huge barrier for people living with substance use challenges

Away From Home (Off- Reserve)

- Harm reduction services and supplies are delivered through:
 - The regional health authorities' public health units
 - Needle exchange programs
 - Supervised injection sites
 - Mobile health vans
 - Outreach health and social service workers (e.g. street nurses)

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- Some NGOs (e.g. AIDS Vancouver Island, Positive Living Northwest, AIDS Society of Kamloops, Fraser Region Aboriginal Friendship Centre, YouthCO HIV and Hep C Society, etc.)

BARRIERS AND OPPORTUNITIES

Beliefs and judgements towards drug use and addiction can be a barrier to providing harm reduction services. Historical legacies of colonization, social exclusion and multi-generational impacts of residential schools have contributed to mental health and substance use issues for Indigenous peoples and impacted trust and willingness to engage with the health care system. People accessing substance use related services may feel judged during the health care interaction and be reluctant to engage in ongoing care. There is a need for education and awareness for service providers and community members regarding culturally safe and effective harm reduction approaches. Historically, health service delivery to on reserve First Nations communities was under the jurisdiction of the federal government, leading to fragmented approaches to care. The transition to the First Nations Health Authority opens up new opportunities for engagement, collaboration and shared service delivery with regional and provincial partners.

Solutions:

1. Continue to discuss harm reduction and the provision of mental wellness and substance use services with regional and provincial partners, enacting Partnership Accords;
2. Continue conversations around harm reduction within the FNHA and engage First Nations communities and, specifically, within the regions;
3. To improve access to accurate data, FNHA supports the Regional HA's to use the Government Standard for Aboriginal Administrative Data when creating new reporting tools.
4. Encourage partnership and collaboration between FNHA Regional Mental Wellness Advisors and Regional Health Authority Harm Reduction Coordinators;
5. Work with First Nations community health nurses and Health centre staff and residential treatment center staff with regards to increasing awareness and accessibility of effective harm reduction services;
6. Deliver regionally facilitated workshops that are designed to increase health service provider capacity/competencies in engaging people who use drugs. It is called Making Connections and is delivered twice a year;
7. First Nations people receive harm reduction information and services as per the other regional health authorities harm reduction sites, 'Toward the Heart' website and through the First Nations Health centers. First Nations community health nurses receive harm reduction and Take Home Naloxone information through the Toward the Heart website and through FNHA STBBI/ HR nurse specialist;
8. Promote and train for the uptake of "Take Home Naloxone" (THN) within communities and regions – currently 30/203 communities are Take Home Naloxone sites to date;

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9. Advocate for increased accessibility and uptake to evidence based opioid substitution therapy within communities;

10. Compassion, Inclusion & Engagement, (CIE) – A FNHA & BCCDC initiative

Drawing on trauma-informed practice, Indigenous cultural safety and humility, health equity and harm reduction frameworks the CIE initiative intends to:

- Co-create interactive learning opportunities for service providers to reflect on their values, attitudes and practices related to working with people who use substances, including First Nations people who use drugs
- Co-create opportunities for service providers to strengthen knowledge, skills and confidence to engage people who use substances, including First Nations people who drugs.
- Co-create opportunities for managers/coordinators to identify and support leadership opportunities in the development of compassionate, inclusive and engaging services for and with people who use substances, including First Nations people who drugs
- Collaboratively identify and develop networks and/or network linkages to deepen and sustain ongoing reflection and practices related to compassion, inclusion and engagement
- The CIE initiative will continue to engage with peers, service providers and leadership across the province to support compassionate, inclusive and engaging harm reduction services. Between 2016 and 2019, two regional health authorities will be selected each year for structured engagement sessions and supported learning opportunities with ongoing support from the First Nations Health Authority each year.

Who has the lead responsibility for this issue?

First Nations Health Authority, in collaboration with the British Columbia Center for Disease control, provincial and regional partners, have a collective responsibility in providing a range of culturally safe, effective harm reduction, substance use and mental health treatment services for First Nations populations in BC.

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20. PRIMARY CARE PROVIDERS

Prepared by: David Tu, MD and David Henderson, MD, Vancouver Native Health Clinic

Community primary care providers (inclusive of family physicians, nurse practitioners, nurses, and other front line allied health professionals) provide the majority of health care to persons living with opiate use disorder (OUD), and carry a significant responsibility towards the prevention of unintentional opiate overdose among these patients. Healthcare for person's with OUD is multi-faceted, and includes establishing the clinical diagnosis and treatment of OUD (inclusive of substitution therapy with methadone, suboxone, or other opiates), managing and preventing other co-morbidities, support to address significant social determinates of health (e.g. community supports, housing, income, and food security) and advocacy for patient access to health system resources. Primary care physicians are also responsible for prescribing medications that are can be involved in patient overdoses.

BACKGROUND

The following patient case illustrates some of the primary care challenges in the prevention of unintentional opiate overdose among patients with OUD:

Marlene was a 32 year old Indigenous single women and mother of 4 children (ages 6 – 17). She received a disability income (relating to depression, chronic pain, HCV infection, and substance use disorder) and lived in subsidized housing. She met criteria for severe stimulant and opiate use disorder since the age of 17. She was started on Methadone maintenance therapy 7 years ago at the time of her most recent pregnancy. Three years ago she regained custody of her two youngest children (the older two remaining in the care of a family member) after demonstrating prolonged abstinence from cocaine and illicit opiate use. She was engaging in treatment for depression, chronic pain, and hepatitis C. Two years ago due to methadone intolerance (persistent sweating) and perceived negative stigma associated with methadone, Marlene was gradually transitioned off of methadone and on to daily witnessed long-acting morphine. This resolved her sweating and improved her pain control. The dose of morphine was gradually decreasing as her physical function and pain control improved.

In 2015, Marlene relapsed into problematic cocaine use, and her two children were removed from her care by the ministry of children and families. Multiple attempts at abstinence through short-term detox were made, but were unsuccessful in part because of delayed access to detox and lack of availability to transition to a residential treatment/stabilization program post detox. Her cocaine use escalated when she became at risk of losing her housing, and she began to intermittently use heroin to “counter act” the stimulant effect. She refused to return to methadone, seeing this a step backwards. She died of a mixed overdose alone in her apartment weeks later. Fentanyl was one of the substances identified by the coroner on toxicology screen.

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BARRIERS AND OPPORTUNITIES

Preventing unintentional opiate overdoses is challenging, and there is no single solution. There is, however, a package of harm reduction and other health services that patients with OUD can access to mitigate the consequences of their disease, which include unintentional opiate overdose. This basic package includes: (1) Opiate substitution therapy with methadone, suboxone, or long acting morphine as a first line, and injectable diacetylmorphine (heroin) or hydromorphone for treatment failures; (2) Access to clean injection equipment and supervised injection facilities; (3) Patient education on overdose prevention and training with provision of naloxone for self-administration; (4) Access to comprehensive primary health care with safe prescribing practices and appropriate mental health and specialist services; and (5) Timely access to detox and outpatient or residential SUD treatment facilities.

Currently, this complete package of services is not available to vast majority of British Columbians with severe OUD. Even where these services are available issues of stigma, criminalization, quality, capacity, structural barriers and lack of cultural modifications limit their impact.

Recommendations:

- **Health Authorities:** Each health authority in British Columbia should commit to a policy of providing this basic package of services to regions with high rates of OUD.
- **Primary Care:** Management of OUD should be considered a basic competency among all primary care providers and BCCPS barriers to physicians prescribing OST should be reduced or eliminated. SUD continuing medical education resources for primary care practitioners should be increased, and safer prescribing practices of substances of potential abuse need to be more widely adopted.
- **Pharmacare:** Naloxone for self-administration should become a pharmacare benefit medication and be considered a standard of care for patients with OUD.
- **Detox & SUD treatment programs:** Increased access and better coordination between detoxification, SUD treatment programs and primary care services needs to be established.
- **Collaborative Action/Knowledge Translation:** Community groups, health researchers and health authorities need to work together to develop new supervised injection facilities and sites that can provide injectable OST.

Similar to other chronic diseases, across all health services for patients with OUD a quality improvement framework with measurable clinical targets should be established. More broadly community and service providers need to work together to address issues of stigma, discrimination, and the negative consequences of criminalization. Resources should also be directed to address significant social determinants of health and other proximal causes of SUD, including experiences of childhood experiences of trauma, and mental illness.

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21. HARM REDUCTION AND CULTURAL SHIFTS

Prepared by: Dan Small, PhD, Department of Anthropology, University of British Columbia

How is that epidemiological truth can be so loud but only scientists and clinicians can hear it? Culture. How is that enormous evidence can exist but policy makers can still ignore it? Culture. The barriers to successful healthcare interventions, particularly in harm reduction (HR), are principally cultural rather than scientific, medical or technical. As such, a cultural change strategy needs to be a part of a response to the overdose epidemic in BC.

BACKGROUND

Culture is such a powerful force that it can even make the sun travel around the earth¹. By way of illustration, despite an established and ever growing evidence base indicating the effectiveness of supervised injection, the Federal Government of Canada actively opposed it bureaucratically, legally and politically for over a decade. Why is it that science was not enough? The answer comes down to the building blocks of culture, implicit and explicit values, that exist in the busy moral borderland that shapes our understanding of drugs. Cultural values of HR and drugs have been described in detail elsewhere but, in summary, they are comprised of stigmatizing notions about drugs including the idea that people choose, without compelling extrinsic explanation, to use drugs². In order to move forward with HR, we need to change values such as the idea that drug users are blameworthy for all suffering and consequences, whether psychosocial or physical, that befall them. The causal focus needs to shift from the individual to social determinants of health. We need to employ a kind of cultural alchemy to transform overdoses from personal to public problems for which government institutions are responsible to address.

The overdose epidemic is entirely amenable to intervention. There is no scientific or medical mystery here: the solutions exist, largely, within the sphere of HR. However, while popular wisdom still reveres abstinence, HR does not hold it as a primary goal, nor count it as a prerequisite to receive life-saving healthcare. This creates associated cultural tension and can hamper the allocation of tax payer resources required for a significant scale up of population health initiatives to address the overdose epidemic. A cultural change strategy is therefore required to identify and address public sentiments that shape political and bureaucratic will.

Insite provides an historical example. The movement around it was largely a cultural one aimed at overcoming narratives about public investment in medically defensible but culturally controversial initiatives. The strategy included a longitudinal initiative comprised of events aimed at creating rival narratives about injection drug use. They included symbolic actions to intentionally produce public pressure to embrace innovative action (e.g. the creation of official conceptual policy such as the 4 Pillars framework and funding for supervised injection). Cultural validators were recruited, with focus on societal leaders (e.g. business, clinical, enforcement, academic, government, cultural), people with lived experience and individuals placed within the system who could deploy resources. A central goal was to

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shift the blaming element of addiction towards an unprejudiced population level model where social determinants of health were the point of action. Without this cultural initiative, legal, scientific and bureaucratic efforts, no matter how earnest, would have fallen short.

Cultural events highlighted needless fatal overdoses and HIV infections, humanized and generated poignancy to create impetus for government action. Each event included symbolic actions (e.g. burning of reports). One event displayed 1000 crosses in a local park to symbolize lives lost to overdoses over a five-year period. As overdoses mounted another event symbolizing death, tragedy and inaction followed with 2000 crosses representing deaths over a decade. Images of those affected by overdoses: mothers, fathers, sisters, brothers and children mourning losses in symbolic graveyards intentionally shaped public sentiment. Similarly, a giant needle, 75 feet long, constructed to represent efficacy of HR, was laid across an intersection. Tens of thousands of moving posters were distributed across Canada to change conventional values from blame to empathy. As the initiative intensified, the perception of a lack of response became associated with insensitivity, inaction and inhumanity. Photographs, videos, media releases, public talks, posters, publications and internet presence continued the cultural change strategy to emphasize that everyone with addiction was rooted in kinship network.

Tens of thousands of letters of support were obtained. Key cultural players were recruited to validate HR. Individuals representing institutions with societal status (e.g. provincial health office, coroner's service and police) were petitioned for their support. All these efforts shaped social climate so that public resources could be allocated, on an urgent basis, to address overdoses. Now, some 13 years later after the establishment of Canada's first supervised injection site, we are once again at the cultural crossroads. Despite the fact that supervised injection has been legally, scientifically and medically established as a key part of the standard of care for addressing injection drug use in Canada³, we have not scaled up injection services appropriately and this, in no small part, accounts for the current overdose emergency. Insite is overburdened with needs it cannot meet with only 12 injection booths and less than round the clock coverage (18 hours per day since its inception in 2003). A socio-political context needs to be created, again, that can move us beyond communications releases to a well-funded epidemiological response.

BARRIERS AND OPPORTUNITIES

Like it or not, collectively held values of the citizenry determine, to a large extent, whether and when public resources are invested. This is especially the case in culturally controversial territory such as that occupied by HR. In my view, a cultural change strategy⁴ also needs to be included as part of a comprehensive plan developed by the BC Overdose Action Exchange to resolve BC's overdose epidemic. Value-based and moral barriers need to be identified and addressed as part of an implementation action plan particularly for HR interventions (e.g. naloxone, expanded supervised consumption, prescription opioids, peer to peer services, street drug testing). The combined symbolic capital of the BCOAE would go a long way in creating the requisite cultural tension (e.g. media pressure, open letters, public events) to move forward and address narrative barriers (e.g. humanization of those lost to preventable overdoses, garnering of public support, generation of crisis through public embarrassment for institutions as necessary). Such a cultural strategy, in its entirety, would take place against a backdrop anchored within

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the everyday lives of those most affected by overdoses in the life world. The cultural goal, then, would be to thoughtfully and intentionally enter the realm of values and morality as part of central work of the BCOAE and, in so doing, open the hearts as much as the minds of the public and policy makers.

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22. STIGMA AND PERSONS WHO USE DRUGS

Prepared by: Jordan Westfall, President, Canadian Association of People Who Use Drugs

BACKGROUND

Stigma has far-reaching negative consequences for the life prospects of persons who use illicit drugs, including in employment, housing, healthcare and personal relationships. Research on public perception suggests that members of the general public have more negative attitudes toward person who use drugs (PWUDS) than toward those dealing with mental illness.

This stigma becomes embedded in the way we communicate to the general public - for example, campaigns focused on destigmatizing drug use often emphasize the potential for drug users “to recover” and to participate in recovery programming. Health communication campaigns focused on stigma reduction to PWUDs should emphasize non-judgmental attitudes towards drug use, rather than emphasizing entry into recovery. Increases in stigma reduction programming can result in increased public acceptability toward support services for persons who use drugs.

BARRIERS AND OPPORTUNITIES

Evidence suggests that educational pamphlets directed at the general public that depict positive stories about persons who use drugs significantly reduced stigmatizing attitudes among the general public towards heroin and alcohol dependent persons. During this public health emergency, people who use drugs respond heroically at the scenes of overdoses. Communicating positive stories of persons using illicit drugs who have contributed to overdose reversals would help reduce stigmatizing attitudes among the general public.

Additionally, the social determinants of health are often disregarded in substance abuse communication. Communication campaigns should place drug use and overdose within its socioeconomic, psychological, and biological context. This would increase acceptance of causal factors of substance use among the general public.

Self-stigma and the potential for community-based harm reduction therapies

Using after periods of abstinence increases the likelihood of overdose. This overdose crisis underscores the need for alternatives to abstinence-based support groups. Abstinence-based recovery programs can promote stigmatizing labels such as “addict”, and reinforce a sense of self-stigma among program participants. Additionally, abstinence-based recovery programming reaches a minority of persons using illicit drugs. Efforts to broaden access to harm reduction self-help programs would increase the amount of persons who use opioid drugs in recovery treatment and support groups.

Increasing access to acceptance and commitment therapy (ACT) that focuses on mindfulness and cognitive behavioral therapy techniques have been proven to reduce the sense of self-stigma felt by persons using illicit drugs. Implementing these programs would serve to address feelings of depression, anxiety, and hopelessness reported by persons who use drugs.

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Finally, changing how government measures policy success would provide a more holistic picture of the issues facing persons using drugs. Efforts need to be taken to measure if a policy influences potential employment prospects, housing discrimination, and the sense of stigma felt by PWUDs and/or the general public toward us.

- “Love People Where They’re At” and communicate without judgment: Communicating positive stories of persons who use drugs in overdose prevention to the general public would reduce public stigma.
- Ensure that drug user unions are included in this process, that their logos are included on posters, along with an opportunity to provide input to the messaging being communicated.
- Communicating information on causal factors and the social determinants of health impacting opioid use and overdose when creating substance abuse campaigns for the general public.
- Focus on reducing subconscious biases underlying stigma in public communication interventions eg. targeting implicit-automatic processes underlying stigma) in stigma reduction campaigns.
- Conduct further academic research into stigma reduction communication targeted at the general public within the province, based on acceptance and non-judgment of substance use.
- Increasing access to group-based acceptance therapies, as this type of therapy has been shown to reduce self-stigma among persons who use drugs.
- Scaling up recovery program alternatives to abstinence-based support groups would greatly increase the population of persons who use drugs accessing recovery programs.
- Overdose warnings and health communication to persons who use drugs should be non-judgmental.
- Include objective measures of stigma and discrimination reduction when measuring the success of implemented policies.

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23. OVERDOSE IMPACT ON FAMILIES

Prepared by: mumsDU-moms united and mandated to saving the lives of Drug Users

Jennifer Woodside for her son Dylan, DOD April 4, 2014

Donna May for her daughter Jac, DOD August 21, 2012

Describing the impact that overdose has on families and communities

BACKGROUND

Significant impact is experienced by each family member, loved one, employer and co-worker, the community and country every time an overdose (OD) or death by overdose (DBO) occurs. That impact begins with substance use disorder (SUD), deepens with each OD and continues for years and generations after a DBO. Each life that is lost not only represents an immeasurable loss of potential and the loss of loved one's hopes, but also depletes the ability for those left behind to cope as they were once accustomed to among society.

Anticipatory impact of a DBO is realized as the loss of relationship, burial costs, hospital expenses, debts incurred on ineffective rehabilitation, loss of household income, loss of productivity in the home workplace and schoolroom, for each person affected, for as much time as is needed to grieve and regroup into a new sense of norm.

Sustained impact occurs when an OD takes place but does not result in either recovery or death, but instead leaves our loved one in a coma or physically/mentally impaired. When an OD results in a coma, family often have the difficult choice of whether or not to sustain a loved one on life support until they die naturally. A prolonged state of hyper-alertness while waiting and wondering what is to come can be taxing and takes a physical, mental and financial toll that is absorbed by all. When OD impairment can be treated within the home, caregiving often becomes a family member's responsibility. Caring for a person in this state, who also has SUD, requires patience, tolerance, and the understanding of where a loved one's belligerence, and sometimes violent, behaviour is really coming from as they go into withdrawal. The weight of these responsibilities can be overwhelming and all-consuming even for the hardest and most compassionate person. Families frequently implode under this tremendous pressure.

Separate and distinct from the anticipatory and sustained impact are the ambiguous impacts of a DBO. Ambiguous costs of experiencing a loved one's SUD and DBO are realized as stress, a sense of shame or failure, survivor's guilt and a feeling of emotional paralysis. Often, for those left behind after a DBO, existence becomes dependant on community, provincial and federal resources for their economic, mental and physical wellbeing. Absent of a socially responsible role model for children to emulate, the impact of a DBO can, and often does, become generational.

Whether it be the anticipatory, sustained, ambiguous or generational costs, SUD and DBO can be classified as a communicable disease that impacts all of society in a substantial way.

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Scope of impact of SUD and DBO unknown

Recent stats supporting BC's declaration of a public health emergency and the reports that DBO is up 88.2% over the same four-month period of the previous year, are statistics which relate only to the number of DBOs that have occurred. These statistics do not reveal the totality and the compounded consequences experienced by families and community before, during and after a DBO. A matrix that measures the consequences of a SUD or DBO has not yet been developed.

BARRIERS AND OPPORTUNITIES

Stigma and shame associated with SUD and DBO continues to reflect the ignorance and misinformation of addiction and is endured by loved ones long after a DBO occurs. SUD and DBO remains a topic that is taboo even among family members. Discussions on the subject can be greatly impeded by one's level of social stature in fear of any association with the disorder. Misunderstanding SUD and DBO has been responsible for keeping the topic off the table and suspended in dogmatic nonsense, by our policy makers, for years. Without an educational intervention we may never ascertain the true breadth of the affects of this disease.

Grief specific to DBO is proliferated by the fact that SUD is not understood even by professionals in the medical and mental healthcare practice. While bereavement groups can empathize with diseases and accidents that have taken their loved ones, however, that same empathy does not extend to someone whose loss is DBO as SUD remains to be seen as a willful behavior.

Areas that Require Action

1. SUD and DBO needs to be taken out of the closet and talked about openly and in an informed manner at every opportunity.
2. Preparation and implementation of a provincial media campaign(s), similar to recent mental health campaigns, directed to reveal the underlying causes, effective treatment models for SUD and the real cost of SUD and DBO on society.
3. Budgeting for an upsurge in health and social care for those who have endured either the SUD or DBO of a loved one must be addressed.
4. Development and implementation of a standardized provincial matrix to measure the consequences of a SUD or DBO.

Lead Responsibility

Federal, Provincial and Community Health, Mental Wellness and Social Care Authorities

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24. YOUTH OVERDOSE PREVENTION

Prepared by: Munroe Craig - Owner, Co-founder, Outreach Director Karmik; Alex Bestos- Co-founder, Peer Volunteer Coordinator

Examining ways in which youth are impacted by the ongoing public health crisis and how the likelihood of youth overdose can be lowered through education.

BACKGROUND

Youth¹⁰ overdoses in British Columbia have been noted to be on the rise from a recent BC Coroner's Report (2016 2). The data which was compiled, however, does not examine whether there has been an increase in youth overdoses since the public health crisis emerged in Vancouver. Youth are more likely to be substance users (experimental or otherwise), and often less likely to seek help. With the increase in substances such as fentanyl being potentially cut into non-opioid substances, the risk of overdose increases for youth who are not expecting to be consuming those substances. Youth also consume pharmaceutical opiates and may not be aware of the risks of these substances or the increased danger of combining them with alcohol.

Peer support systems have been found to have mixed results in disseminating harm reduction information due to youth sometimes being uninformed about the substances they are consuming. The B.C. Coroner's Report found that youth tended to be with friends when an overdose occurred, meaning that peers can be a lifeline for individuals who are having an overdose. A combination of Good Samaritan laws and the dissemination of harm reduction practices could lower the likelihood of youth overdose, or in the case where overdoses occur, could help to mitigate the likelihood of death. In our work as frontline harm reduction workers in the nightlife community, we have found individual feelings about calling for an ambulance can be mixed, with some peers supporting their friend going to a hospital, and some being uncomfortable with interactions with authority figures.

Working to educate individuals about their liabilities when dealing with authority figures would greatly alleviate the worries that individuals have when an ambulance is called. Further, better education for youth in school as well as those who are no longer in school could help to alleviate the likelihood of overdoses for those who choose to use substances. While increasing awareness of fentanyl has gained significant political traction in public health, it is important to recognize that overdoses can also occur from other illicit and licit drugs as well. Education should not be confined strictly to opiates. For non-fentanyl related substances access to reagent testing would allow youth better know which substances they are consuming and act accordingly. Finally, in tackling overdoses among youth, it is important to seek out and support local projects which work specifically with youth, as broad based campaigns can only be so effective and can miss individuals who are already integrated into local harm reduction efforts.

¹⁰ Defined as anyone under the age of 30 years old

BARRIERS AND OPPORTUNITIES

Key opportunities to support youth overdose prevention and current barriers to implementation include:

- Funding:
 - Supporting local projects which work specifically with youth can target youth most at risk and those already integrated into local harm reduction efforts.
 - Organizations which work with underserved communities tend to be understaffed and underfunded. While there is broadly recognition of the efficacy of programs such as Insite, and Trip Project, funding for these resources is difficult to acquire. Further the focus on opiate harm reduction as opposed to comprehensive harm reduction programs means that some communities of substance users, particularly non-opiate users, are unable to obtain harm reduction services and peer education.
- Research:
 - Make data available to local organizations to better inform peer education and target messaging appropriate to local context.
 - While the BC Coroner's Report is a useful tool in understanding youth substance use and overdose prevention programs, more recent data is still unavailable to local organizations. Peer Education requires access to scientific data in order to make informed decisions. Canada currently lacks data on substance using communities which may be useful to those working in educating the populace.
- Access:
 - Reduce barriers to access take home naloxone and increase access to reagent testing
 - Access to resources for low income individuals such as naloxone may be limited. Further, individuals who may know opiate users but are not opiate users are required to designate themselves as opiate users if they want to receive take-home naloxone to help their friends and loved ones.
 - Access to reagent testing is also limited both to those who know about its existence and those who can afford to order it online.
- Trust:
 - A combination of Good Samaritan laws and the dissemination of harm reduction practices could lower the likelihood of youth overdose or mitigate risk of death
 - A significant barrier to implementation of overdose prevention programs is a lack of trust. Communities which are afraid to call for ambulances for fear of legal repercussions, or have histories associated with structural and physical violence, are at greater risk of missing or ignoring prevention strategies.
- Education
 - Educating individuals about their rights dealing with authority figures and providing better education of youth in schools regarding the risks of overdose and related harms from the full spectrum of psychoactive drugs, including but not limited to fentanyl, is key.

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IMPORTANT REFERENCES

Egilson, Michael. Preventing Death After Overdose: BC Coroners Service Child Death Review Panel A Review of Overdose Deaths in Youth and Young Adults 2009-2013. Rep. N.p.: BC Coroner's Office, 2016.

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25. THE ROLE OF COMMUNITY IN OVERDOSE PREVENTION

Prepared by: Russell Maynard and Christy Sutherland MD CCFP DABAM, Portland Hotel Society

Community is one of the most effective tools in the effort to prevent overdose, and can only succeed with the help and support of the public health agencies. The THN program is an excellent example of this. Programs such as THN demonstrate the power of community to leverage and scale-up an intervention

BACKGROUND

The Drug User's Resource Centre (DURC) is a Portland Hotel Society (PHS) operated drop-in centre with a Peer Board. Since it began its Take Home Naloxone (THN) program, it has trained over 1000 people in the use of THN kits. DURC has run a training module once a month in a series of Harm Reduction 101 modules for Peers. This regular program reaches about 250 people per year.

The format for the training at DURC is based on a very proactive model. Community can be uniquely equipped to react quickly to overdose (OD) crisis as they occur: Increasing OD response and naloxone training beyond the regular programming.

Proactive training includes:

- Training that is targeted to youth, couples, poly-substance users at highest risk of OD such as those who drink alcohol, non-injectors who think they're 'safe', users who have recently OD'd, and individuals recently released from jail or out of treatment. Proactive training means hands on safer injection training, staggered use training, naloxone and OD response training.
- Training anyone who is at risk of witnessing an OD, training families and close peer groups as a whole responder unit in multi person responses to OD's.
- Taking naloxone and OD training out into the streets to reach harder to engage users such as sex workers.
- Innovative steps include making an effort to engage and train dealers and distributors in OD response, safer user practices and naloxone training.

Every opportunity that Community has to support and train members of the community is very important. The Downtown Eastside (DTES) is a vibrant community - but one that is characterized by poverty and a heavy burden of medical co-morbidity.

PHS, as a community-based NGO, has always recognized that the building and healing of community in the DTES is based on a step-by-step process and that each of these steps is vital in its potential to strengthen and develop the social capital in the DTES.

Public Health, working through Community, can play a significant and proactive role in reducing risk of OD by explicitly addressing stigma amongst the public, amongst the drug using community, and amongst policy makers across BC.

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Key points for successful community engagement in a program include:

1. Strong partnerships with Peer Boards in any location that hosts Harm Reduction initiatives.
 - a. Peer Boards should be grass roots rather than managed by public health in order to ensure the development of social capital and the exchange of learning between professionals and the drug using community.
 - b. The BCCDC has an excellent opportunity to train the peer boards to do ongoing work within their communities, even after the BCCDC intervention is over.
2. Work with drug users in a manner that empowers them through education and respectful discourse.
3. Expanding the scale of Harm Reduction programming into all public health spheres.
4. Harm Reduction innovation should come from the drug users and be a community based intervention rather than a medical intervention.
5. Naloxone should be not attached to a prescription and be available for free for every drug user and family or friends of drug users in the province.
6. Enhanced education for drug users, including the differences between opiates, the effects of alcohol and benzodiazepines on opiate response, and the value of openness around use so that people are not alone when using. Every training linked to OD intervention builds the social change and develops the social capital that will reduce the risk that is so prevalent with opiate use.
7. Strong messaging from clinicians and researchers about the safety of naloxone as well as strong support from leaders to remove the barriers to naloxone.
8. Community workers have the opportunity to have ongoing one on one interactions with drug users. These rapport building, small moments of connection allow for ongoing growth and expansion of a public health mandate.

The most effective approach to scaling up public health interventions is to have those in the drug using community play a key role in the development and dissemination of knowledge and training. This creates a sustainable and active environment to develop the social capital and knowledge that will reduce risks around drug consumption.

The potential to make change when Public Health and Community work in partnership with community is demonstrable and profound. Systems such as public health are highly capable at providing excellent large scale services. Working closely with community can enhance this by connecting with one-on-one care that people need to feel a part of something comes from association and belonging. This is the role of community.

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BARRIERS AND OPPORTUNITIES

It would be valuable to community organizations to emphasize the safety profile of naloxone.

For example, including information about how naloxone is a unique medication in terms of its safety and non-toxicity. As per Boyer's 2012 guide to OD management:

Naloxone can be administered without compunction in any patient, including patients with opioid dependence. Concerns that naloxone will harm patients with opioid dependence are unfounded.

(Boyer, E. (2012) Management of opioid analgesic overdose. N Engl J Med 367:146-155.)

Community members in the downtown east side have found naloxone distribution to be too slow in the face of an opioid overdose epidemic. These delays have caused increased death in this community and drug users are angry and grieving. Additionally, the community worries that this slow response is secondary to the strong stigma that they often experience in their interactions with health care.

PHS Community Services Society is delighted to participate in this ongoing dialogue in order to work together to support debate and learning, as well as the delivery of timely health interventions to this community.

PHS has been purchasing and distributing its own supply of naloxone throughout our projects. This naloxone is located in crash kits in all of our housing projects for PHS staff to use for overdose intervention. We track our overdose interventions through a central reporting system. We have developed an Overdose policy guide for our staff that includes the use of naloxone. Please see our Overdose intervention poster attached. This is posted in all PHS projects to guide our staff during the many overdoses they manage each week.

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ADDITIONAL MATERIALS

<p>1. A vision for cannabis regulation: a public health approach based on lessons learned from the regulation of alcohol and tobacco</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/01 A vision for cannabis regulation.pdf</p>
<p>2. CPSBC: Methadone Maintenance Program-Clinical Practice Guidelines</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/02 CPSBC- Methadone Maintenance Program Clinical Practice Guideline.pdf</p>
<p>3. Controlling illegal stimulants: a regulated market model</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/03 Controlling illegal stimulants a regulated market model.pdf</p>
<p>4. HCSM OAT Policy April 2016</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/04 HCSM OAT Policy.pdf</p>
<p>5. Moving Towards Improved Access for Evidence- Based Opioid Addiction Care</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/05 Moving Towards Improved Access for Evidence- Based Opioid Addiction Care.pdf</p>
<p>6. A New Approach to Managing Illegal Psychoactive Substances in Canada</p>	<p>http://www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/06 A New Approach to Managing Illegal Psychoactive Substances in Canada.pdf</p>
<p>7. PHS: Overdose Response</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/07 PHS- OD response.pdf</p>
<p>8. Public Health Perspectives for Regulating Psychoactive Substances</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/08 PublicHealth Perspectives for Regulating Psychoactive Substances.pdf</p>
<p>9. CPSBC: Safe Prescribing of Drugs with Potential for Misuse/Diversion</p>	<p>www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/09 CPSBC Safe Prescribing of Drugs with Potential for Misuse Diversion.pdf</p>

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BC OVERDOSE ACTION EXCHANGE

10. Harm Reduction as Standard of Healthcare	www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/10 HarmReduction as Standard of Healthcare.pdf
11. Cultural alchemy and supervised injection: anthropological activism and application	www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/11 Cultural alchemy and supervised injection anthropological activism and application.pdf
12. A case study in culture change	www.bccdc.ca/resource-gallery/Documents/Statistics and Research/Publications/Epid/Other/12 A case study in culture change.pdf

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