Objective of the Report

Information about drug use in British Columbia (BC) and its adverse consequences is available through a variety of sources. These sources include surveys, cohort studies, and administrative data. Surveys may be administered to the general population or specific subgroups such as youth or high risk populations. Information may be collected for defined geographic areas or the province as a whole, and for calendar or fiscal years. This report collects and collates the most recent data available regarding substance use and associated morbidity, mortality and enforcement patterns. This report also includes up to date information on harm reduction strategies used to mitigate these adverse outcomes. We discuss interpretations, comparisons, and limitations of the data to provide the reader with a greater understanding of the bigger picture related to drug use in BC.[1]

Executive Summary

CHAPTER 1

Demographics—

summarizes the demographic characteristics of BC population including geographic distribution, life expectancy and mortality.

- In 2013 the population of BC was estimated to be 4,581,978.
- Of the five health authorities, Fraser Health has the smallest geographic area but a population of 1,689,875 (about 37% of BC's population). Northern Health is the largest geographic area but is the region with the smallest population (284,000).
- Life expectancy at birth in BC continues to increase in all health authorities but disparities between them continue. In 2011, life expectancy at birth was 82.01 years overall in BC; Vancouver Coastal Health was highest at 83.67 years and Northern Health almost 5 years lower at 78.86 years .

CHAPTER 2

Substance use trends—

explores substance use trends among the general and high risk populations in BC. A subsection reports drug use patterns among youth – both in the general and high risk populations. Key findings include:

- Among people who use illicit drugs in Vancouver (Urban Health Research Initiative)
  - Crack cocaine use has declined since reaching a high of 70% in 2008, but remains the highest reported drug used (34% in 2013).
  - Crystal methamphetamine use (injection and non-injection) reached its highest reported level to date in 2013 (17.8%).
  - The availability (ability to obtain drugs within 10 minutes) of illicit drugs increased from 2005 to 2007 but has remained fairly constant since.
- Among clients accessing harm reduction supplies throughout BC in 2013
  - Crack cocaine use is highest in the Northern Health region (67%).
  - Heroin use is highest in the Fraser Health region (54%).
  - Marijuana use is highest in Interior Health (60%).
- Among BC youth in school, self-reported use of all psychoactive substances declined from 2008 to 2013.
- Among a convenience sample of street-involved youth in Victoria and Vancouver
  - Crystal methamphetamine and cocaine are the most widely used illicit drugs after marijuana.
  - Reported crystal methamphetamine use in Victoria increased from 6% in 2011 to over 50% in 2013 .

CHAPTER 3

Morbidity—

analyzes substance related morbidity patterns. Hospitalizations related to tobacco, alcohol, and illicit drugs are analyzed by health authority. Overdoses experienced and witnessed are reported from various surveys. Emergency room visits related to overdoses in Vancouver and overdoses at Vancouver's supervised injection site are reported. Calls to: BC ambulance determined as ingestion poisoning, Drug and Poison Information Centre, and HealthLink BC in 2013, and ambulance administered naloxone events throughout the province over time are shown.
Key findings include:

- Tobacco use results in more hospitalizations than alcohol or illicit drugs in BC; 28,206, 21,542 and 4,326 related hospitalization respectively in 2011. Tobacco-related admissions are declining but those related to alcohol are increasing.

- In Vancouver, alcohol is the main substance responsible for overdose-related emergency room visits; visits appear higher in income assistance and/or disability assistance cheque issuance week.
- Experiencing an overdose varied considerably by risk population and site:
  - About 30% of high risk recreational-use adults in Vancouver and Victoria.
  - About 18% of street involved youth in Vancouver but 28% in Victoria.
  - Adult harm reduction clients varied from 10-18% between health regions.
- BC Ambulance Service receives between 150 and 200 calls per week which are coded as Ingestion Poisoning calls.
- BC Poison and Information Centre receives an average of 70 calls each day about poison exposures.
- HealthLink BC received between 400 and 500 calls from the public related to alcohol and other drugs per month in 2013.
- In 2013, the BC Ambulance Service reported 2,011 naloxone administration events throughout BC. Over the last 5 years Fraser Health had the highest number of naloxone events (3,211) followed by Vancouver Coastal Health at 2,868 events.

CHAPTER 4

HIV and hepatitis C virus—

describes HIV and hepatitis C virus (HCV) disease background and patterns in BC, including case demographics, exposure categories, and testing/treatment strategies.
Key findings include:

HIV:

- Newly diagnosed HIV cases in BC generally declined from 408 cases in 2003 to 237 in 2012; an increase was reported in all health authorities in 2013 (272 total cases); this increase in HIV identification was associated with increased testing.
- About 12% of cases were female (33 female and 239 male in 2013)
- Over half of cases diagnosed in 2013 were identified as men who have sex with men.
- There were 29 new HIV cases among people who inject drugs in 2013 (same as 2012) down from 136 cases in 2003.

HCV:

- The BC HCV diagnosis rate continues to be higher than the Canadian average; 41.5 and 19.3 cases per 100,000 population respectively in 2012.
- After a steady decline since 1997, the number of cases of HCV identified in BC rose in 2013 to 2,105 (from 1,886 in 2012).
- HCV testing has increased annually; in 2013 there were more than 200,000 HCV tests performed
- From 2008 through 2012, all regional health authorities experienced an overall decrease of 24 month HCV seroconversion in people who had repeat tests. In 2013 rates were similar in all health authorities.
- New effective treatments for HCV with fewer side-effects are being developed, are expensive and currently not yet widely available in BC.

CHAPTER 5

Mortality—

analyzes deaths in BC related to substance use.

- Vancouver Downtown East Side has an overall mortality rate almost five times higher than the province.
- In 2011, the tobacco-related death rate was three times the alcohol-related death rate, which was three times the illicit drug rate (87, 23 and 7 cases per 100,000 population respectively).
- Illicit drug-related mortality rates in 2011 were highest in Fraser Health
- In 2013, illicit drug overdose deaths in BC increased to over 300 deaths
  - About a quarter of these deaths were female
  - Males aged 20-29 years had the highest rate followed by males 40-49 years.
  - The vast majority (90%) of these deaths were determined to be accidental.
- Since 2007, overdose deaths due to mixed drugs and multiple narcotics have been the leading cause of illicit drug deaths.
- BC is experiencing an increase of fentanyl-detected deaths (15 in 2012 to 51 in 2013).
- In 2010 there were 72 deaths identified in people prescribed opioids.

CHAPTER 6

Harm Reduction—

describes provincial safer sex, safer injection and safer inhalation supply distribution. Vancouver's supervised injection facility (Insite), BC's Take Home Naloxone program, methadone maintenance therapy (including the change to Methadose) and the NAOMI and SALOME studies are discussed.
Key findings include:

- 76% of British Columbians support harm reduction
- In 2013, the harm reduction program distributed more than 4 million condoms throughout BC.
- Needle/syringe distribution throughout BC increased from 4.18 million in 2006 to over 8 million in 2013.
- Population rate of needle/syringe distribution varies by health authority. Vancouver Coastal Health had the highest rate and Fraser Health the lowest (at 450 and <50 needles per 100 population respectively).
- Almost half of harm reduction clients who inject drugs reported difficulty acquiring needles, citing supply distribution center operating hours and distance as the main barriers.
- In 2012, there were 376,149 visits to InSite by 9,259 unique individuals.
- In its first 2 years, the BC Take Home Naloxone program has 51 sites, trained 2,214 people, dispensed 1,215 naloxone kits and 125 overdose reversals were reported.
- Between April 1, 2012 and March 31, 2013, there were 14,833 patients in BC's methadone maintenance program.
- In February 2014, BC changed methadone formulation from a compounded 1mg/ml solution to Methadose - a liquid 10 times more concentrated.

CHAPTER 7
Enforcement—

describes drug-related crime and police enforcement practices in BC and explores alternative enforcement practices to incarceration, such as Vancouver's Drug Treatment Court. Drug trafficking patterns are also discussed.

- Possession charges comprised almost 80% of Controlled Drugs and Substances Act offences (CDSA) in BC in 2012; trafficking accounted for 14%, production 6%, and importation/exportation 0.5%.
- In 2012, four of the top five census metropolitan areas with the highest drug crime rate in Canada were in BC.
- The rate of CDSA offences in Vancouver has consistently declined since 2006; in 2013 the rate was less than half the 2006 rate.
- Of all BC drug offences in 2012, cannabis represented about 70%, cocaine 17% and heroin 2.9%; but in Vancouver cannabis was 40%, cocaine 37%, and heroin 15%.
- There were more pharmacy robberies and break-ins in the first six months of 2014 than in all 2013.
- The estimated value of drugs seized by Canada Border Services Agency in 2013 was over $47 million CDN.

Background

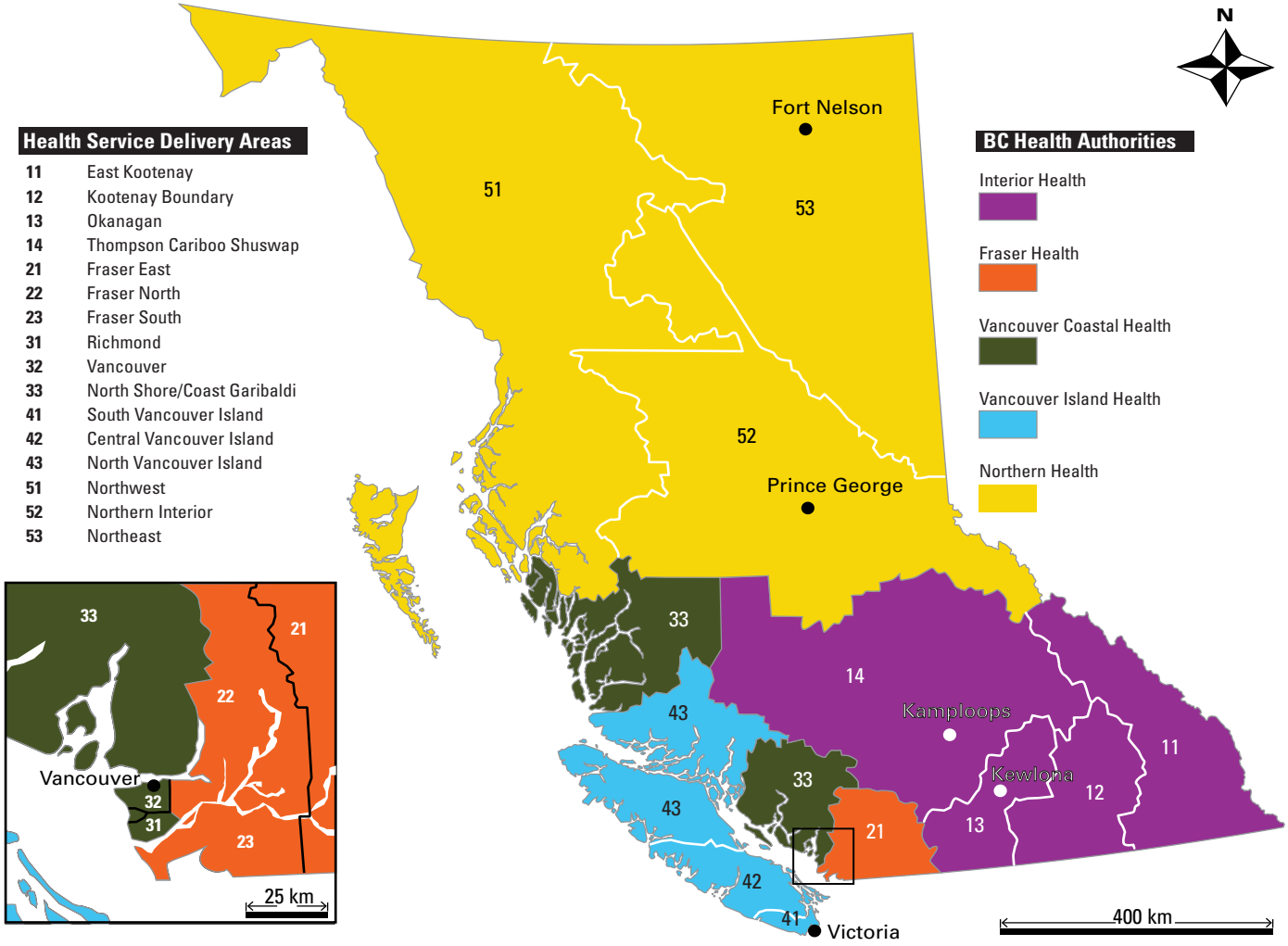
Harm Reduction Committees and Health Authorities in BC

The wellbeing of people who use drugs (PWUD) is threatened by high-risk drug use, limited access to healthcare and social services, and stigma. Harm Reduction (HR) is a range of public health policies designed to reduce the harmful effects of high-risk behaviours through a range of non-judgmental strategies. HR provides the knowledge, skills, resources and support for individuals, their families, and communities to be safer. The principles of HR, along with prevention, treatment and enforcement, make up the four pillars approach to drug addiction - a coordinated and comprehensive strategy to reduce harms from the use of psychoactive substances to create safer, healthier communities.[2] The four pillars approach was first implemented in Europe and adopted by City of Vancouver in 2000.[2]

The BC Drug Overdose and Alert Partnership (DOAP) is a multi-sectoral committee that was established to prevent and reduce the harms associated with substance use (DOAP members are listed on page 1). The group identifies and disseminates timely information about harms related to substance use including overdose, adverse reactions to contaminated products, and other emerging issues. At quarterly meetings, committee members provide context and share insights about data from their respective agency. Provisional data, including monthly illicit drug overdose deaths, and weekly data: ambulance calls for poisonings, Vancouver hospital emergency room attendance for overdose, overdoses at InSite, and Drug and Poison Information Centre calls related to drugs, are available to the DOAP members on a password protected website. Concerns and questions can be posted on the website and communicated to the members who work together to identify the need for alerts and to develop solutions.[3]

The BC Harm Reduction Strategies and Services (HRSS) Committee uses evidence-based policy and guidelines to reduce the harms of drug-related events. The HRSS committee has representatives from the five BC regional Health Authorities (HA), the BC Ministry of Health, BCCDC, First Nations Health

Figure 1.1 **Map of regional health authorities and health service delivery areas in BC**



Authority (FNHA), and other key harm reduction stakeholders to provide a structure to facilitate coordination of HR in BC.[4]

Each HA is responsible for providing health services within a defined geographic region[8]: Fraser Health (FH), Vancouver Coastal Health (VCH), Vancouver Island Health Authority (VIHA), Interior Health (IH), and Northern Health (NH). Each HA is further divided into three or four Health Service Delivery Areas (HSDAs); for example VCH is comprised of the Richmond, Vancouver and North Shore/Coast Garibaldi HSDAs. These regions are illustrated in Figure 1.1. Each HSDA is made up of smaller geographical units called Local Health Areas (LHAs). Using the example of VCH once more, Vancouver HSDA is further divided into six LHAs: City Centre, Downtown East Side, North East, Westside, Midtown, and South Vancouver.

The BC First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. In 2013, the FNHA assumed the programs, services and responsibilities formerly held by Health Canada's First Nations Inuit Health Branch – BC Region.[5]

First Nations people in BC and across Canada experience statistically significant health disparities, including disproportionally high substance addiction/abuse and infection rates of HIV and hepatitis C (HCV). Factors, such as colonization, discrimination, the experience of residential schools, and high rates of unemployment have exacerbated these health inequities. Based on the 2007 BC Tripartite First Nations Health Plan, the three partners of BC First Nations, the Province of BC, and the Government of Canada are working together "to improve health services, shift the emphasis to wellness and preventing illness, improve performance tracking and the creation of a new First Nations health governance structure".[6]