

The image shows the 'The Healing Quilt' monument, a large, colorful quilt panel mounted on a wall. At the top, there is a stylized eagle with spread wings. Below the eagle is a large, multi-colored star. The quilt panel is made of various colored triangles and squares. The text '2018 OVERDOSE Action Exchange' is overlaid on the top half of the image. The text 'THERE IS NO ONE TO CARE,' is on the left side of the star, and 'IF YOU DO NOT CARE' is on the right side. At the bottom right, it says 'BUD OSBORN 1947-2014'.

2018 OVERDOSE Action Exchange

THERE IS NO
ONE TO CARE,

IF YOU DO
NOT CARE

BUD OSBORN
1947-2014

"The Healing Quilt faces west, and although I see it every day, it hasn't faded into the background - instead I'm always seeing it fresh. Much like Bud Osborn's writing. Seemingly simple, its complexity is astonishing. This one line: "There is no one to care // if you do not care" - we can read it 100 times and never once wonder, who's Bud talking to?

I don't think he's talking to the powerful. I think he's talking to us. We have to make demands of ourselves.

It's normal to become so traumatized and damaged after years of war to not remember when you stopped caring about yourself and each other. I think Bud saw that coming. I fear now that we don't care that we don't care. *The Healing Quilt* demands that we do, because we are in this together, and so we must seek the justice that feels like love."

– Karen Ward



Curtis Boyd, Quesnel, 2015

Land acknowledgement

We respectfully acknowledge that this meeting took place on the unceded territories of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), Stó:lō and Səlilwətaʔ/Selilwitulh (Tsleil-Waututh) Nations.

Cover art: Sharifah Marsden, Jerry Whitehead, and Corey Larocque, Vancouver

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DIES, Vancouver

FOREWORD

We are pleased to present the 2018 Overdose Action Exchange (ODAX) meeting report. Much like the two previous ODAX meetings, the aims were to provide a safe space to review and challenge our current response to the overdose crisis and to put forward new and innovative strategies. British Columbia should be in an exceptionally good spot to respond to the overdose crisis: a history of grass roots innovation in harm reduction, strong peer-led advocacy, a track record in research excellence, an experienced team of health care professionals, an engaged law-enforcement community, and political leadership that has made the overdose crisis a priority.

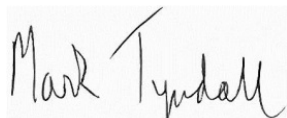
The breakout sessions highlighted significant progress over the past year, including the establishment of the Overdose Emergency Response Centre, more timely access to data, the expansion of overdose prevention sites, a focus on Indigenous approaches to prevention and care, the scale-up of the [Take Home Naloxone](#) program, increased involvement and consultation by people with lived experience, anti-stigma and public awareness campaigns, drug testing sites, access to lower barrier opiate agonist therapy, and the expansion of injectable [hydromorphone](#) programs. Many of these innovations and accomplishments were due to the energy and commitment of people attending the meeting.

Despite these very positive steps, the number of overdoses and overdose deaths in BC remain stubbornly consistent and staggeringly high. We are still failing to prevent drug overdoses and have not adequately responded to the new reality—the street drug supply is now toxic. As long as the primary source of drugs comes from an unregulated, unreliable and criminal source, people will continue to overdose. In fact, much of our “success” to date lies in our ability to prevent overdose deaths and not overdoses themselves. Countless lives have been saved through post-overdose interventions—our network of professional first-responders, an army of people trained to administer [naloxone](#) and rapid interventions at overdose prevention sites—all of which are primarily designed to reverse overdoses once they happen. If we truly want to prevent overdoses, we must reduce the exposure to this unregulated drug market. This will ultimately require a major shift in the way that we currently prescribe, monitor and regulate opioids.

Although it is now widely accepted that addiction should be seen as a health issue, our drug policies continue to prioritize a criminal justice approach to drug possession along with applying criminal punishment for the myriad of illegal activities associated with the acquisition of drugs. No matter how progressive and available our care and treatment programs are, we continue to push illegal drug use to the margins and make it extremely difficult for people to access the services when and where they need them. Decriminalization of all drug possession is now seen as a critical component of a comprehensive response to the overdose crisis.

The excellent representation and contribution from people with lived and living experience highlighted the incredible social and health challenges confronting people who are using drugs. Punitive policies to access welfare, few prospects for housing, a revolving door with the criminal justice system, limited access to appropriate addiction care and hostile societal attitudes toward drug users were identified as major obstacles that require urgent attention.

While much has been accomplished, we hope that ODAX 2018 and this report can further move the dial to a comprehensive response to the overdose crisis that addresses the immediate need to provide access to a safer drug supply, scale-up harm reduction programs, expand access to care and treatment, as well as address the upstream factors that perpetuate the overdose epidemic. Much is still required if we are to see a reduction in overdose deaths in the coming year.



Dr Mark Tyndall
Executive Medical Director
BC Centre for Disease Control

MEETING BACKGROUND



On June 8, 2018, the British Columbia Centre for Disease Control (BCCDC) welcomed over 160 people to participate in the third British Columbia Overdose Action Exchange (ODAX) at the Morris J. Wosk Centre for Dialogue in Vancouver.

There were 59 organizations represented (see Appendix C) from

a wide range of stakeholder groups including people with lived experience, policy makers, community organizations, public health leaders, government, academia, emergency health services, law enforcement, researchers and medical experts. While there are multiple groups who continue to work hard on the overdose crisis, ODAX is a unique opportunity to have many of the key stakeholders and decision makers in one place for the day.

The first ODAX was held at BCCDC on June 9, 2016 and was a “call to action” that guided the provincial response by identifying 12 key priority actions. A [meeting report](#) and [primer](#) from this meeting are available on the BCCDC website. The second ODAX meeting took place on June 16, 2017 and identified 10 key actions that can be found in the [meeting report](#).

ABOUT THIS REPORT

Similar to last year’s meeting, much of the day was spent exchanging new and innovative ideas in small groups that each looked at one of seven questions ([see Appendix A](#)). The actions included in this report were pulled from notes taken in the small group sessions, as well as a pre-meeting with [peers](#).

Notes from the small-group sessions were cross-referenced with recordings to form a data set. An open coding structure was employed across all questions. Question prompts were not used to guide the coding because almost all conversations touched on topics beyond the scope of each question prompt. Initial actions were written from the codes; these were sent back to small group facilitators and a peer for review.

In addition to this process, a post-meeting questionnaire was distributed to key stakeholders to contribute feedback relevant to Indigenous engagement. Their feedback was incorporated into the report under the existing sections. The draft report was reviewed by multiple stakeholders including people with lived experience.

DISCLAIMER

The intention of this meeting was to provide an open and safe environment to discuss the overdose crisis in BC. By design, the meeting included stakeholders who came from a wide range of disciplines, organizations and perspectives. ODAX was not intended to reach consensus; rather, the recommendations in this report capture the ideas expressed by participants and range from practical to provocative.



We need to ensure that [peers] have access to safe, clean prescription medication and connection with social supports, so they can be on the pathway to hope.

– Minister Judy Darcy [MMHA]



PEER PRIORITIES

We use the term “peers” to refer to people with past or present lived experience ([PWLE](#)) of substance use who are considered experts in the field. Peers can provide insights into the realities of substance use and their local risk environments, and the applicability of programs and policies. Meeting attendees agreed that peers have been, and should continue to be, at the forefront of the overdose response in the province, and are often the first responders to an overdose. Support for peers recognizes their essential contributions to sustainable solutions as well as their right to safe and equitable employment.

Hiring, employment and compensation

- **Continue and increase meaningful presence of peers as active participants and leaders embedded in all processes of research, service delivery and overdose prevention activities**
 - Expand inclusion of peers to all areas that affect them, including mental health services, primary care services, research and policy and program development
 - Build peer capacity for engagement through the Compassion, Inclusion and Engagement (CIE) Project, a partnership between the BCCDC and First Nations Health Authority (FNHA)
- **Pay peers appropriately for their work**
 - Payment practices currently vary across the province; however, stable and fair employment is necessary to a good quality of life
 - Ensuring fair pay mitigates tokenism and honours peers as experts in their lived experience (See [Peer Payment Standards](#))
- **Support the rights of peer workers as workers; support their right to form their own associations or union**
- **Hire peer coordinators in every health authority**
 - Peer coordinators should have some level of lived experience with substance use and liaise with harm reduction coordinators, community partners, and other organizations to influence systems change within health authorities
 - Consider supporting capacity-building for peer coordinators to forge a new way forward that is inclusive of all voices that need a seat at the table

Advocacy

- **Support emerging peer organizations, peer-led solutions, and peer spaces**
 - Provide support for peers in navigating the grant system; fund peer initiatives, peer-led solutions and opportunities for peer to peer involvement throughout the province
 - Continue advocating for leadership and providers to work with peers in equitable and sustainable ways
 - Recognize the importance of community in peer spaces such as tent cities
 - Look for ways to build and increase peer connection in other spaces

“To “keep 6” is to be the lookout for police. “Six on foot” means there are officers walking nearby. These reminders in Market Alley seem redundant - everyone has eyes for six here.”

– Karen Ward

INDIGENOUS ENGAGEMENT

We recognize that Indigenous peoples are overrepresented in the overdose crisis and their voices are underrepresented at all levels in the public health response, including all Overdose Action Exchanges. The BCCDC is beginning a journey of reconciliation that includes working towards improving Indigenous engagement through collaboration, partnership, hiring processes, and recognizing the contributions and capacity of our existing Indigenous staff.

In the spirit of reconciliation, we invited those ODAX participants who self-identified as Indigenous (e.g. First Nations, Inuit, and/or Métis) or who worked in Indigenous-led organizations (e.g. FNHA and Aboriginal Friendship Centres) to provide feedback on all seven of the small group discussion questions, as well as one additional question on Indigenous engagement.

Feedback from participants involved in this process has been integrated throughout the report. This process was limited in its ability to capture all voices with a stake in the issue. We will seek to ensure that next year's ODAX meeting focuses on an integrated commitment to Indigenous engagement.

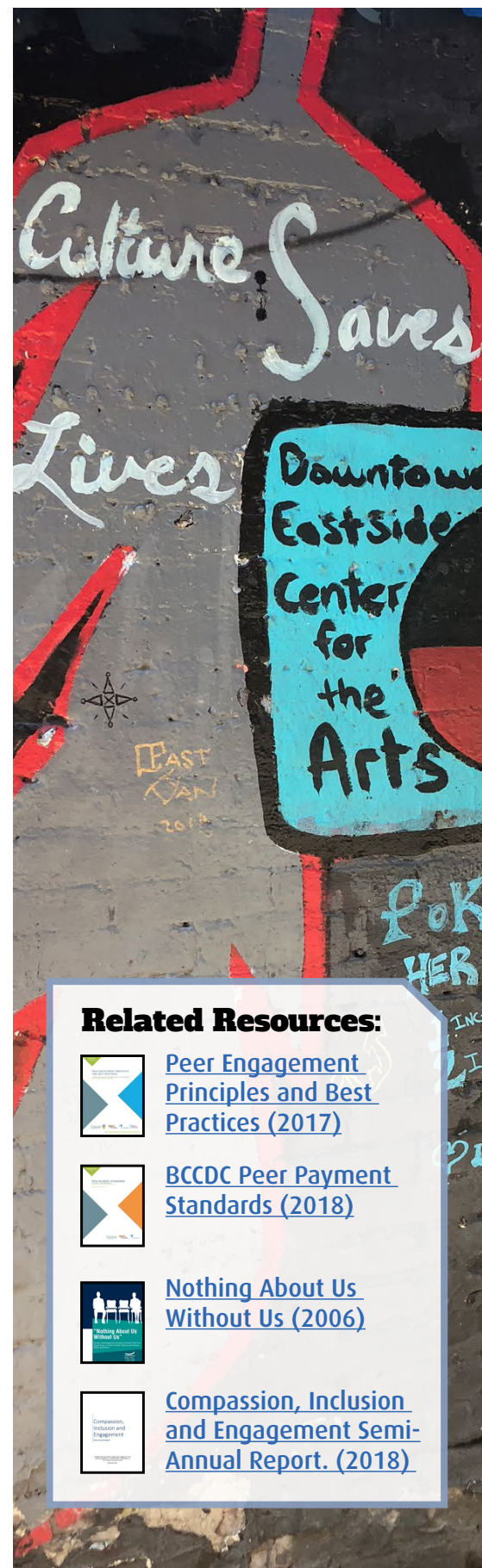


Not Just Naloxone Training, FNHA, 2018

TRUTH AND RECONCILIATION CALLS TO ACTION

Throughout the report we have woven the [Truth and Reconciliation Commission of Canada's Calls to Action](#) around engagement with Indigenous communities. This report highlights the following specific calls to action:

- #22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.
- #23. We call upon all levels of government to to:
- I. Increase the number of Aboriginal professionals working in the health-care field.
 - II. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
 - III. Provide cultural competency training for all health-care professionals.



Related Resources:



[Peer Engagement Principles and Best Practices \(2017\)](#)



[BCCDC Peer Payment Standards \(2018\)](#)



[Nothing About Us Without Us \(2006\)](#)



[Compassion, Inclusion and Engagement Semi-Annual Report. \(2018\)](#)

The root causes of the opioid crisis are social injustice, criminalization, and crimes against Indigenous people.

– Minister Judy Darcy [MMHA]

INDIGENOUS PRIORITIES

All efforts directed towards the overdose crisis should be informed by the recommendations of the Truth and Reconciliation Commission (TRC), an understanding of the historical and continuing impacts of colonization on Indigenous peoples, and an appreciation of the importance of culture in healing. Meaningful Indigenous inclusion is not only the work of key organizations (BCCDC included); it is important in any initiative, even if these organizations or initiatives are not explicitly “Indigenous-specific.”



Ways organizations can advance the unique health needs of Indigenous peoples include:

Truth and Reconciliation Commission (TRC) recommendations

- Identify and respond to the TRC Calls to Action related to overdose response in ways that meet local needs as determined by the community
- Embed the TRC’s calls for action throughout all documents that involve Indigenous peoples

Cultural safety

- Recognize the disproportionate overdose event and mortality rates experienced by Indigenous peoples
- Be more inclusive of Indigenous perspectives, both within and outside of our organizations, through meaningful engagement during the planning process and follow-up for events and activities
- Address the needs of all Indigenous peoples through Indigenous inclusive and/or specific programming and resources, as determined by Indigenous peoples
- Support existing programs that foreground culture as intervention
 - FNHA scale up of programs such as [Culture Saves Lives](#), [FNHA’s Indigenous Wellness Team](#), [Not Just Naloxone](#) (NJN), and [Compassion, Inclusion and Engagement](#) (CIE) programs
 - Other Indigenous-led programs, such as [Chee Mamuk](#)
 - Metro Vancouver Indigenous Services Society (MVISS)

Engagement

- **Meaningfully engage with Indigenous peoples and organizations on the topic of overdose response**
 - Support established relationships with Indigenous-led organizations in your local area, a non-exhaustive list includes FNHA, the BC Association of Aboriginal Friendship Centers (BCAAFC), Métis Nation BC (MNBC), and the Urban Indigenous Opioid Task Force (UIOTF)

Workforce

- **Support Indigenous peoples and organizations involved in the overdose response**
 - Provide employment to Indigenous peoples applying for overdose response activities
 - Invest in Indigenous-specific overdose response activities
- **Hold up the voices of Indigenous service providers**
 - Support front-line workers to work in alignment with policy changes
 - Support Indigenous-led peer organizations, such as the [Western Aboriginal Harm Reduction Society \(WAHRS\)](#)

Information sharing

- Form a working group on Indigenous overdose data involving FNHA, law enforcement, and the BC Coroners Service
- Recognize that Inuit and Métis data are not consistently captured, and these populations are underrepresented due to structural issues



Related Resources:



[Truth and Reconciliation Commission of Canada: Calls to Action \(2015\)](#)



[Honouring our Strengths: Culture as Intervention in Addictions Treatment](#)



[FNHA: Harm Reduction](#)



[First Nations Mental Wellness Continuum Framework](#)



THEMES

Actions discussed at the meeting were organized into the following six themes:

DRUG POLICY	<ul style="list-style-type: none"> • Advocacy • Federal and provincial legislation • Provincial/regional initiatives
SAFER SUPPLY	<ul style="list-style-type: none"> • Prescription opioids • Drug checking • Explore alternative models
PREVENTION	<ul style="list-style-type: none"> • Stigma and public messaging • Education • Youth • Transitional care
OVERDOSE PREVENTION SERVICES	<ul style="list-style-type: none"> • Establishing overdose prevention services • Extending overdose prevention service models • Overdose prevention services & housing • Peers
NALOXONE	<ul style="list-style-type: none"> • Scale-up • Support community
TREATMENT AND RECOVERY	<ul style="list-style-type: none"> • Shift treatment model • Detox • Opioid Agonist Therapy • Recovery • Accountability

**"If this is to be the end of the war on drugs -
the war on drug users-
then ending this war means not only ending this
crisis, but the next crisis too -
and while this big change
(how we understand pleasure, pain, and freedom)
will take time, and work, and care,
and a more just world will be the result, it's true**

**I fear that an entire generation of users -
the last generation of illicit drug users -
will be sacrificed, for no reason at all."**

- Karen Ward

DRUG POLICY

Collectively, decriminalization and reforms to existing drug policy was considered to be an imperative and urgent area of focus. Attendees commented on the need to effectively define decriminalization and examine alternative policy models. Changes to various policies and legislation at both the federal and provincial/regional levels were consistently voiced.



Advocacy

- **Create a decriminalization task force to define, evaluate and draft a proposal for revised legal regulation in Canada**
 - Develop clear objectives for decriminalization with consensus from multiple stakeholders, using other drug policy models as road maps (e.g. Portuguese model)
 - Consider and address the interprovincial effects of the legalization of controlled substances in BC
 - “Resilience-based” (as opposed to “deficiency-based”), health equity and humanistic approaches should be applied to ground research and discussion
 - Use current regulatory framework for cannabinoids for prescription and non-prescription opioids
- **Reframe issue and leverage influence through partners and stakeholders**
 - Canadian Medical Association (CMA) and Canadian Association of Chiefs of Police (CACP): draft a position paper and report about decriminalization
 - Union of BC Municipalities (UBCM): update rules and regulations pertaining to standards of care
 - Partner with Law Enforcement Action Partnership (LEAP)
 - Frame the benefits of decriminalization in economic, equity, human rights, and healing terms

This crisis needs to become a health issue, not a criminal issue.

– Mayor Gregor Robertson
[City of Vancouver]



Related Resources:



[Federal Exemptions \(Section 56\) to the Canadian Controlled Drugs & Substances Act “Exemptions” \(2015\)](#)



[The Good Samaritan Drug Overdose Act: What You Need to Know \(2017\)](#)



DTES, Vancouver



The opioid crisis should be seen in the context of structural violence.

– Mark Tyndall [BCCDC]

Federal and provincial legislation

- **Evaluate the impact of the federal *Good Samaritan Drug Overdose Act* and revise accordingly**
 - Clarify the law to reduce inconsistencies and likelihood of charges (i.e. ensure that the legal protection is applied consistently)
- **Remove the application process for exemption from [Section 56](#) of the *Controlled Drugs and Substances Act (CDSA)*, so that prescribers of [Opioid Agonist Therapy \(OAT\)](#) can provide timely care for their patients without the delay of processing the exemption**
 - Fear of being charged prevents people who use substances from accessing OAT—especially racialized and Indigenous people—as well as individuals in the correctional system
- **Enhance provincial law enforcement policies and responses**
 - Reassess the process in which members of law enforcement are incentivized for good work (removing arrests of marginalized individuals from the equation) and increase accountability measures as it pertains to racial profiling
 - Limit police presence in treatment/harm reduction services and peer-centered spaces in order to lessen barriers to access among people who use substances
 - Evaluate and improve anti-stigma and cultural safety training for members of law enforcement and all service providers. Engage people with lived experience in the training
 - Create a culturally safe diversion program that provides people with options beyond arrest for simple possession, petty crime, parole violation, etc. Consider alternative models such as the [tribal healing wellness court model](#) from the United States

Provincial and regional initiatives

- **Create overdose prevention communities**
 - By exempting entire communities within Section 56, simple possession charges and barriers to access services would be reduced
- **Discontinue the practice of charging people in [red zones](#)**
- **Share provincial law enforcement data among stakeholders to improve transparency**
 - Expedite the exchange of information as it relates to seized substances and their origin and content
 - Regularly monitor charges for simple possession and other minor offence data. Use this knowledge to set benchmarks for reducing the number of charges (until such time that new decriminalization legislation is in place)

SAFER SUPPLY

The need to get safer drugs into the hands of people who need them was one of two major themes to emerge from ODAX 2018. There is no question that the current drug supply is toxic as over 80 percent of people dying from an overdose have fentanyl in their system. However, the idea that people should have access to a regulated supply of pharmaceutical opioids runs counter to the current narrative that we should be reducing the supply of opioids. It is also widely recognized by law enforcement and communities that much of the harms and criminal activity associated with drug use is in the acquisition of illegal drugs. The provision of a regulated opioid supply would lower the risk of overdose, reduce violence and crime and provide a real opportunity to engage with people using drugs.

Prescription opioids

- **Design and implement a program for low-barrier access to hydromorphone pills**
 - Support the Health Canada pilot project to provide a regulated supply of hydromorphone pills to people dependent on opioids
 - Explore a variety of dispensing models including Secure Dispensing Machines (SDM)
 - Consult people with lived experience when designing these programs to enhance uptake and reduce barriers
 - Pilot this program in communities outside of the lower mainland and particularly in northern, rural, and remote communities
- **Recognize injectable Opioid Agonist Therapy (iOAT - using hydromorphone) as a source for a safe supply of opioids**
 - Currently, iOAT is viewed as an extension of treatment and a therapeutic option for those with severe opioid use disorders who have been unable to adhere to other OAT
 - Re-frame as a source of safe supply and scale up across the province in response to a toxic drug supply
- **Recognize the need for access to a variety of safe opioids, including heroin and fentanyl**



The only thing we can do is place clean, safe drugs in the hands of people now.

– Sarah Blyth [OPS]

- Attendee

- **Enhance drug checking by coupling test strip implementation with further technology to quantify amounts of fentanyl in a substance**
 - Drug checking alone does not provide a solution to the lack of access to a safe drug supply and may not be useful to opioid users due to ubiquity of fentanyl contamination
- **Change the way test strips are distributed to reach those who need them**
 - Drug checking needs to reach people who use at home and not only people who are using at an overdose prevention site
 - Expand access to drug checking in rural, remote and Indigenous communities



- **Explore alternative models for a safe supply of stimulants**
- **Explore non-medicalized models that do not involve prescriptions**
 - Pilot a project for distribution of drugs without a prescription
 - Allowing [PWLE](#) to grow their own medicines and move away from historically-entrenched distributions of power that disadvantage PWLE

◻ PREVENTION

Stigma continues to be the driving force of isolation, criminalization and barriers to services that people who use substances experience. Until people start to understand and acknowledge how their own misunderstandings and ideologically based decision-making processes contribute to the opioid overdose crisis, we will be limited in our ability to move forward. It is imperative that we address stigma so as to avoid increasing the amount of loss we have already been faced with. Combating stigma through public messaging and education were discussed as upstream steps towards preventing further overdoses. Youth and people in transitional care are populations that need to be prioritized.

Stigma and public messaging

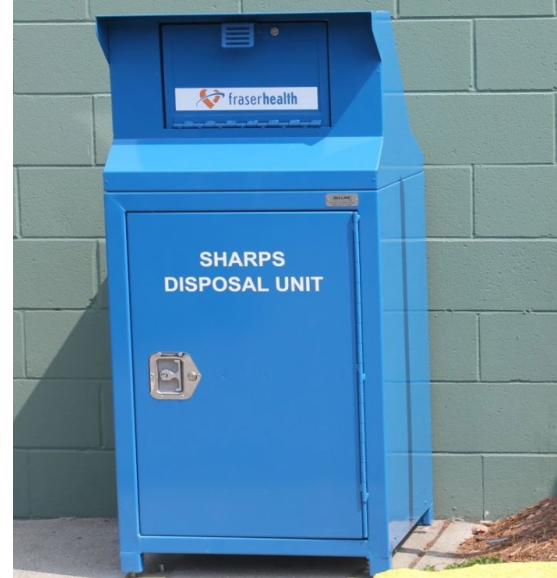
- **Create a cultural shift by changing language and media norms**
 - The stigmatizing terms “drug abuser” and “addict” have been banned in certain media channels. If other media outlets do the same, this will create a cultural shift
- **Recognize that criminalization is the largest driver of stigma**
 - Frame the overdose crisis as a public health issue, not a criminal issue
 - Whenever possible, avoid using language that draws attention to the criminality aspect of an issue
- **Change the narrative around who use substances and why**
 - Address underlying social and structural determinants that can drive and sustain substance use and health inequity (e.g. colonization, racism, classism, poverty, stigma)
 - Addiction is not a personal failing
 - Keep in mind that labelling all people with lived experience as “traumatized” contributes to stigma and takes away personal agency
- **Conduct an effective anti-stigma campaign**
 - Canadian Drug Policy Coalition (CDPC) could lead the campaign in partnership with [PWLE](#)
 - Build on the way that existing public health campaigns acknowledge that people use alcohol without stigmatizing them. Educate the public about protective factors as well as risk factors



SCS Pandora St., VIHA, 2018

Some of the worst stigma that people face is with health care providers.

– Attendee



Sharps Disposal, FHA, 2018

Related Resources:

[SACY: Substance Use Health Promotion Initiative \(2017\)](#)



[Kelty Mental Health- Youth and teen substance use](#)



[Here to Help](#)



[Health Link BC - Alcohol and Drug Problems](#)



[Health Link BC - Parenting Articles](#)



[OERC: Terms of Reference](#)



[Indigenous Communities: HIV and HCV in Federal Prisons](#)



[Community Reinforcement and Family Training](#)

Education

- **Use strengths-based, skill-building approaches instead of fear-based educational programming**
 - Look to [SACY](#) (School Age Children and Youth) - Substance Use Health Promotion Initiative – and other resiliency-based education over the traditional [DARE \(Drug Abuse Resistance Education\)](#)-style programming
 - Incorporate teachings about the social determinants of health, gender-based violence, and stigma in education around substance use
 - In high schools as well as medical, nursing, and other vocational schools, be aware of fear-based messaging and invite PWLE to work on improving current curriculum and allow them to share their perspectives during teaching about substances
- **Ground service providers' education about trauma and violence-informed care in the social determinants of health**
- **Structure cultural safety and humility courses so that students are more accountable for their learning**
 - Use a variety of media, such as video games and virtual reality to help engage students
- **Prioritize evidence-based approaches**
 - Community buy-in is important for project sustainability. Hold dialogue with communities to explain the evidence

Youth

- **Design youth-specific interventions and campaigns**
 - Youth are often ignored and under-served from initiatives that affect them the most
 - Engage youth with lived experience in policy development
 - Connect youth with community resources about substance use and trauma (for example, [YouthCo](#) and the Provincial Health Services Authority's (PHSA) [Indigenous youth wellness program](#))
- **Keep families together**
 - Consider the importance of family in prevention and recovery
 - Create family-centered supports for PWLE in collaboration with Indigenous families and Indigenous-led child and family service organizations

Transitional care

- **Create inreach programs that will support [PWLE](#) transitioning out of corrections**
 - Post-release care should focus on preventing overdose
- **Call for changes to the welfare system that will allow people with warrants to be eligible for welfare**
- **Expand Medical Services Plan (MSP) coverage to increase access to mental health and substance use services**

Smokey D, Vancouver

OVERDOSE PREVENTION SERVICES

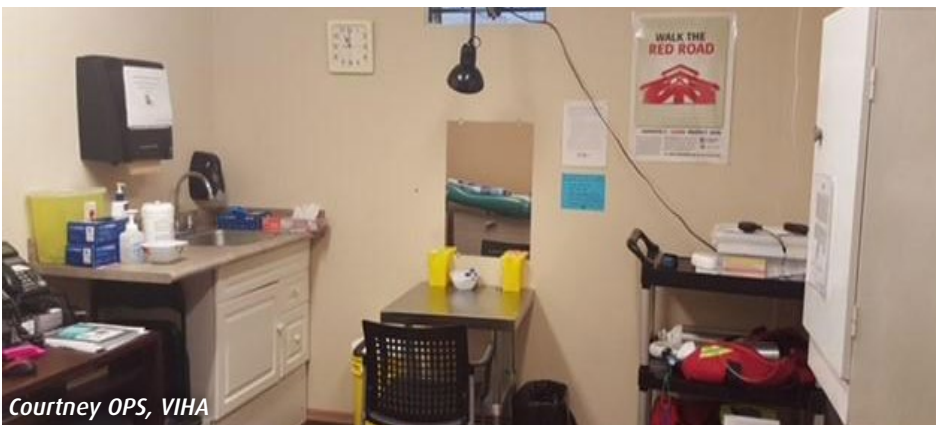
Overdose prevention services (OPS) provide safe and accessible harm reduction services. Attendees emphasized the importance of increasing accessibility by expanding the reach of current OPS models.

Establishing OPS

- Define the role of health authorities with regard to funding and advocacy for OPS expansion
 - Support community-based organizations, particularly peer-led, to be involved in staff training and service delivery
 - Provide education and support for all OPS
 - Begin implementing OPS in shelters and other community settings
- Create a requirement for all OPS workers to meet harm reduction standards before opening an OPS
- Implement Ministry directives to ensure overdose prevention services are available in high risk areas
 - Invoke a ministerial order to create and expand OPS in areas where there is municipal or law enforcement opposition
 - Support rapid implementation of OPS by providing clear minimum standards based on safety, flexibility and responsiveness to local context
- Update the [existing OPS guidelines](#) to highlight the different models and steps to opening a new OPS
 - Create a short-form version of OPS guidelines that can be used as a “quick reference” resource

Extending OPS models

- Expand OPS to facilitate wrap-around care
 - Address health and social needs, not just overdose response, whenever possible
 - Provide Opioid Agonist Therapy (OAT) / Injectable Opioid Agonist Therapy (iOAT) at OPS (look at [Molson PHS model](#))
 - Include OPS in medical clinics



Courtney OPS, VIHA


“OPS [are] more than just ‘overdose prevention,’ they are a community hub. Much more potential than a medically driven SIS. Peer involvement makes it this way.”

– Attendee

Related Resources:



[BCCDC OPS Guidelines](#)



**“They talk, we die.
We talk, they listen,
we live.”**

– Erica Thomson [FHA]

- **Prioritize the need to increase accessibility of OPS**
 - Expand reach through mobile services, especially in rural, remote, and Indigenous communities
 - Create infrastructure for inhalation services
 - Extend operating hours of OPS
 - Consider the relationship between concealment, OPS accessibility and stigma when evaluating current and future OPS models and locations
- **Create social spaces for [peers](#) outside of OPS**
 - OPS are currently being used as community spaces for peers. Create dedicated social spaces where peers can meet outside of OPS

OPS and housing

- **Integrate OPS into modular housing in each health authority**
- **Evaluate the current incentives/requirements for incorporating OPS into housing**
 - Incorporate harm reduction service provision into housing contracts; retrofit into older buildings and social housing
 - Prioritize stakeholder involvement by including organizations such as BC Housing in talks about solutions moving forward
- **Rethink the design of prospective housing**
 - Maximize design options that will strengthen community connectedness, specifically ones that include shared common spaces. Single person housing units do not promote community building
 - Ensure staff are properly trained to support and engage with tenants around overdose prevention, including culturally safe and non-judgmental support and education for people using alone in their units

Peers in OPS

- **[PWLE](#) must be central to the functioning of any OPS**
 - Develop the capacity of community-based organizations to hire and support peer workers

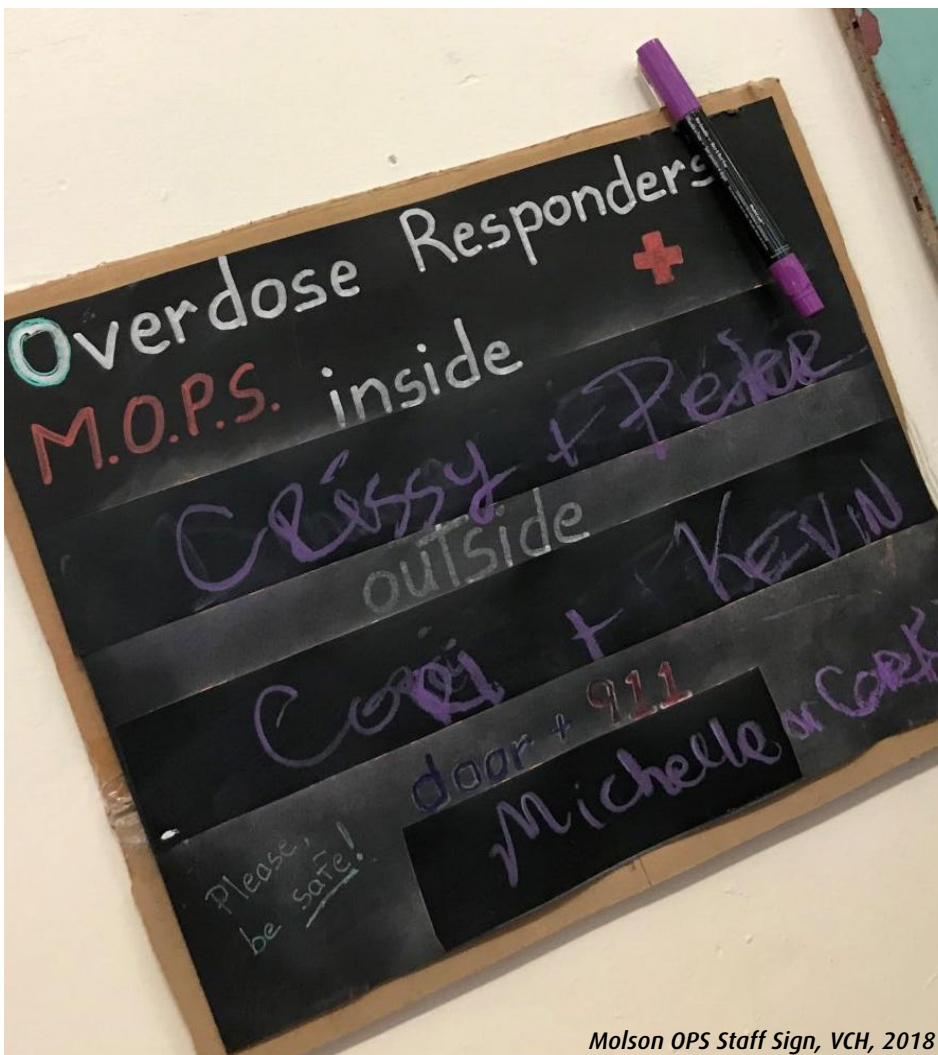


Mobile supervised consumption unit, IHA

◻ NALOXONE

The [Take Home Naloxone](#) and Facility Overdose Response Box programs have made a significant impact on lowering overdose deaths since they were made available, with increasingly high numbers of both kit distribution and overdose reversals since 2016. The success of the Take Home Naloxone program is a result of its peer-driven nature. Continuing to expand naloxone distribution and training is critical to advancing overdose response initiatives.

- Further expand [naloxone](#) distribution and training
 - Mandate naloxone training for all community shelters, as well as Inuit, Métis, and First Nations communities
 - Conduct naloxone kit building events; involve peers to share stories
 - Ensure all criminal justice services are carrying and using naloxone at all times required
 - Provide naloxone kits to individuals beginning [OAT](#)
 - Ensure naloxone is available in recovery and treatment settings



Molson OPS Staff Sign, VCH, 2018



[We're] getting tired of painfully navigating a system of harm.

We need autonomy, purpose, & inclusion.

– Erica Thomson [FHA]



Related Resources:



[BCCDC Take Home Naloxone Program](#)

■ TREATMENT AND RECOVERY

There are currently large barriers to accessing treatment and recovery services in BC. It was clear from [peers](#) at the meeting that current services are not meeting the needs of people who use them and there is a need to re-conceptualize the system. Effective treatment plans take into account the social determinants of a patient's experience, and are flexible and accountable.

Shift treatment model

- Move beyond medical models towards a holistic model of care that includes mental, emotional, social, and spiritual aspects at the systems level
 - The current biomedical model does not serve the needs of diverse [PWLE](#)
 - Provide connection to psychosocial supports, including housing and income/disability assistance
 - Support approaches that utilize Indigenous "cultures as intervention" and direct resources to monitor, evaluate and potentially expand on these initiatives
 - Provide family-focused, gender-inclusive, trauma-informed and culturally safe wrap-around care, including employment, education and psychosocial supports in non-clinical settings (i.e. look to model from the Metro Vancouver Indigenous Services Society, based out of the [Metro Vancouver Aboriginal Executive Council](#))
- Expand access to medicalized options
 - Provide options for treatment that meet the needs of a wide range of PWLE
 - Expand treatment options beyond [methadone](#) and [SUBOXONE](#), including implementing a stimulant prescription program and supplying all forms of OAT
 - Change policies and guidelines to provide prescriptions for people who do not meet criteria for addiction
 - Expand the Crosstown Clinic model provincially to provide access to a safe supply of heroin and/or [hydromorphone](#)

**We don't even have a system to improve.
[The] system is yet to be built.**

– Cheyenne Johnson [BCCSU]



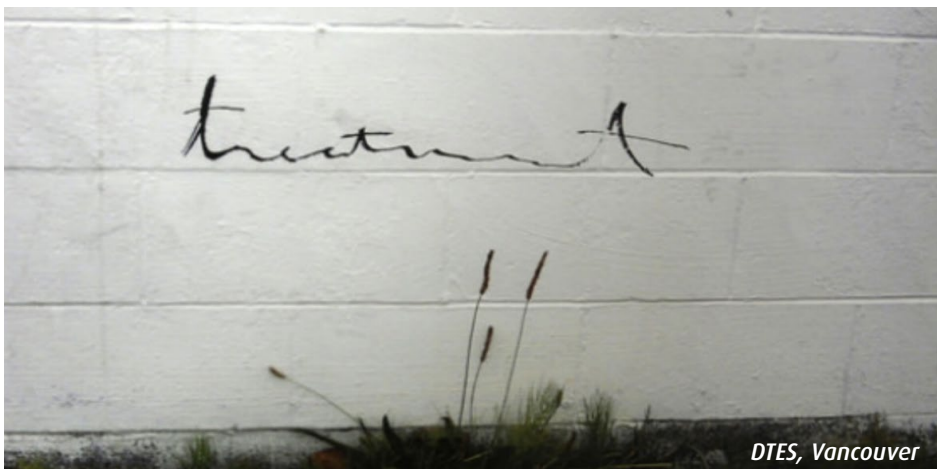
DTES, Vancouver, 2018

Detox

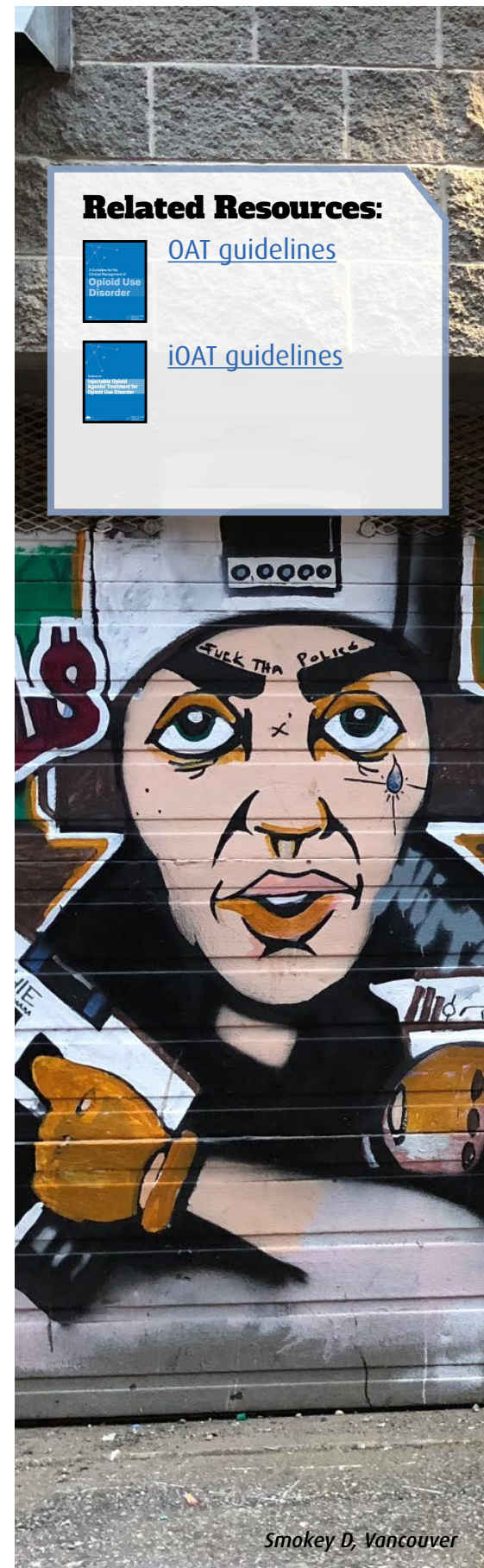
- **Improve transparency of detox services and integrate within the continuum of care**
 - Increase transparency within detox centres by creating and implementing licensing and regulation standards, including provision of [OAT](#) and [Take Home Naloxone](#), as well as continuing training/education programs for staff

Opioid Agonist Therapy (OAT)

- **Evaluate and revise existing OAT guidelines**
 - Evaluate and modify guidelines related to:
 - a) the transition of the [methadone](#) program to the [methadose](#) program
 - b) efficacy of slow release methadone
 - Current OAT guidelines are inflexible, unrealistic and do not address practical realities of [PWLE](#); this decreases adherence to treatment
 - Penalize pharmacies that pay cash incentives to clients to maximize their profits and exploit the people using their services and undermine the treatment system
- **Increase accessibility of OAT and iOAT**
 - Recognize that all patients are different and require tailored approaches to care, including people who have difficulty accessing or being engaged/retained in treatment and those who wish to continue to use substances recreationally during treatment
 - Change standards in residential and treatment settings that present barriers to access for OAT/iOAT
 - Consider expansion of iOAT to pharmacies, community health clinics, OPS, and supervised consumption and injection facilities
- **Increase education requirements for OAT prescribers**
 - Include mental health supports along with OAT for clients and families as there is a lack of discussion around addressing people who have concurrent disorders (mental health and/or addiction)
 - Discuss side effects of OAT with potential clients



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Smokey D, Vancouver


Related Resources:



[OAT guidelines](#)



[iOAT guidelines](#)



**Talking is nothing—
passionate, eloquent
talk is nothing without
action.**

– Elder Shane Pointe

Recovery

- **Improve transitional care**
 - Hire addictions specialist nurses to work on the HealthLinkBC line (811)
 - Work with corrections and law enforcement to address the issue of lack of coordination of care at discharge

Accountability

- **Create a channel for patients to communicate inappropriate prescribing practices**
 - Physicians who do not prescribe appropriately, such as refusing iOAT due to stigma, should be held accountable by the College of Physicians and Surgeons
 - People who make complaints are not usually notified of the outcome of their complaint

▣ MOVING FORWARD...

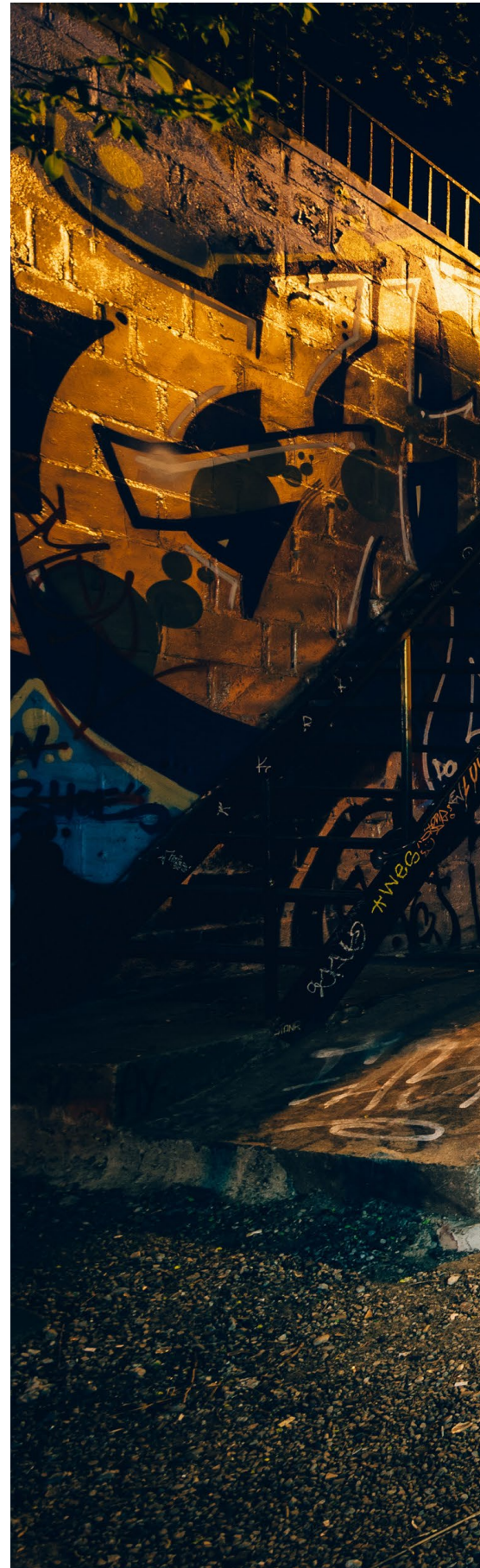
ODAX 2018 provided an opportunity for a wide range of stakeholders to exchange current strategies and brainstorm new, innovative approaches to solve the overdose emergency in BC. Chief among the areas of focus were:

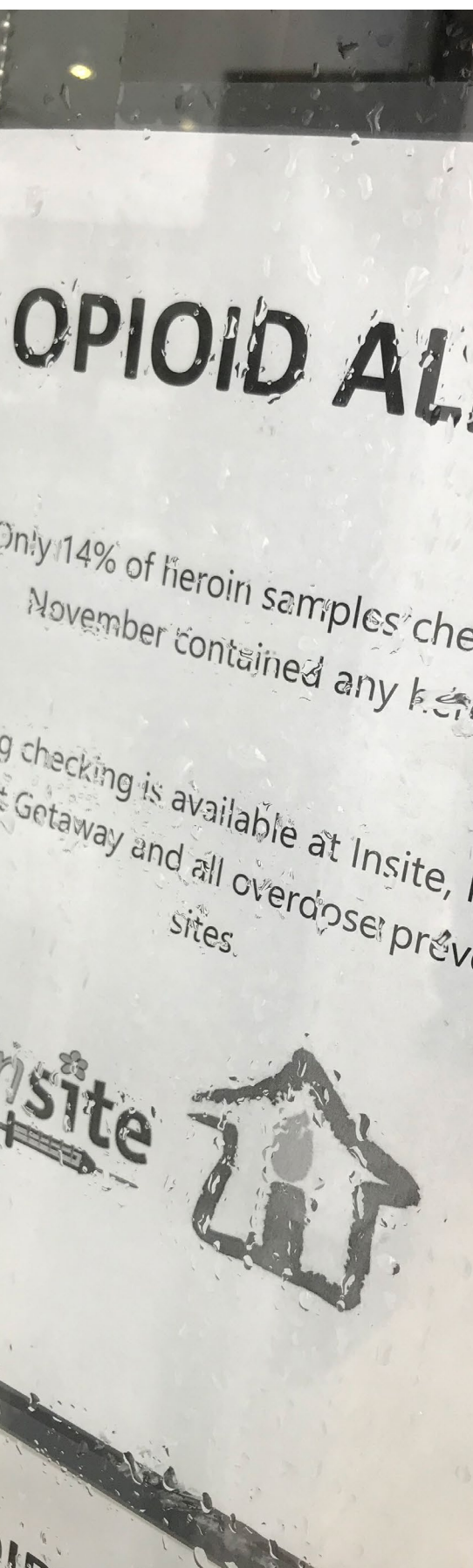
- access to a safer supply of drugs; and,
- reforms to drug policy that would forge the path toward decriminalization.

Words and statements contained within this document are meaningless without action, accountability and evaluation—a reality understood by those who attended ODAX, as well as those who compiled this report.

▣ **APPENDIX A: SMALL GROUP QUESTIONS**

1. In an environment where the street drug supply is “contaminated,” how can we provide people with safer options?
2. What lessons can be learned from the low-barrier overdose prevention sites established during the public health emergency to improve the impact and effectiveness of supervised injection services in BC?
3. How do we build a better addiction treatment system for BC and what are the priority areas that could improve the system?
4. What should be the goals of law enforcement in supply reduction or disruption, drug possession, drug dealing, drug courts and the prison system as it relates to the overdose crisis?
5. Much of our response to the overdose crisis is shaped by drug policies that are based on prohibition and supply-side control. What might be learned from the Portuguese model of decriminalization and health system improvements?
6. The vulnerability to drug overdose is influenced by both upstream factors and structural barriers. How can we address some of the upstream factors and structural barriers that impede our response to the overdose crisis in both the short and long term?
7. Stigma and discrimination is a major barrier in responding to the health and social consequences of addiction. What are some specific approaches that can reduce stigma and create a cultural shift toward understanding the complexities of drug use, addiction and associated harms?





APPENDIX B: RESOURCES

Overdose Action Exchange Meeting Report (2017)

"British Columbia Overdose Action Exchange Meeting Report" (August 2017).

Retrieved from <http://www.bccdc.ca/resource-gallery/Documents/bccdc-overdose-action-screen.pdf>

Compassion, Inclusion and Engagement Partnership

"Compassion, Inclusion and Engagement Semi-annual Report." (February 6, 2017).

Retrieved from <http://www.bccdc.ca/resource-gallery/Documents/CIE%20Semi-annual%20Report%20Jan%202017.pdf>

"Peer Engagement" (2018).

Retrieved from <http://towardtheheart.com/peer-engagement>

Federal Exemptions (Section 56) to the Canadian Controlled Drugs and Substances Act "Exemptions" (August 20, 2015).

Retrieved from <https://www.canada.ca/en/health-canada/services/health-concerns/controlled-substances-precursor-chemicals/exemptions.html>

Good Samaritan Drug Overdose Act

"The Good Samaritan Drug Overdose Act: What You Need to Know" (July 17, 2017).

Pivot. Retrieved from http://www.pivotlegal.org/fact_sheet_what_you_need_to_know_about_the_good_samaritan_drug_overdose_act

OPS Guidelines

<http://www.bccdc.ca/resource-gallery/Documents/BC%20Overdose%20Prevention%20Services%20Guide-Final%20October%202%2C%202017.pdf>

Peer Payment Standards

"Peer Payment Standards for Short-Term Engagements" (February 2018). Retrieved from http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer_payment-guide_2018.pdf

SACY: Substance Use Health Promotion Initiative

"SACY: Substance Use Health Promotion Initiative" (2017). Retrieved from. <http://www.vsb.bc.ca/sacy>

Take Home Naloxone

Take Home Naloxone (2018). Retrieved from <https://towardtheheart.com/naloxone>

OAT Clinical Guidelines

OAT: "A Guideline for the Clinical Management of Opioid Use Disorder" (June 5, 2017). Retrieved from http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

iOAT: "Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder" (2017). Retrieved from <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

Truth and Reconciliation Commission of Canada: Calls to Action

"Truth and Reconciliation Commission of Canada: Calls to Action" (2015). Retrieved from http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf

APPENDIX C: ATTENDEES*

AIDS Vancouver Island	Karmik
Alaska Department of Health & Social Services	Lookout Housing and Health Society
Alberta Health	Metro Vancouver Aboriginal Executive Council
ANKORS	Ministry of Health
Association of Registered Nurses of BC	Ministry of Mental Health and Addictions
Association of Registered Psychiatric Nurses of BC	Ministry of Public Safety and Solicitor General
BC Centre for Disease Control	Northern Health
BC Centre on Substance Use	Overdose Emergency Response Centre
BC Coroners Service	Overdose Prevention Society
BC Emergency Health Services	Pacific AIDS Network
BC Mental Health and Substance Use Services	PHS Community Services Society
Canadian Centre on Substance Use and Addiction	Pivot Legal Society
Canadian Drug Policy Coalition	Positive Living Fraser Valley
Canadian Association of People Who Use Drugs (CAPUD)	Providence Crosstown Clinic
Centre for Health Evaluation & Outcome Sciences	Provincial Health Services Authority
City of Vancouver	Provincial Overdose Mobile Response Team
College of Pharmacists of BC	Public Health Ontario
College of Physicians and Surgeons of BC	R.E.D.U.N.
Cool Aid	RainCity Housing
Correctional Health Services	Sheway
CSUN	SOLID Outreach Society
Culture Saves Lives	Surrey Fire Service
DUDES Club	University of Alberta
First Nations Health Authority	University of Victoria
Fraser Health	Vancouver Area Network of Drug Users (VANDU)
Health Canada	Vancouver Coastal Health
Health Emergency Management BC	Vancouver Native Health Clinic
Interior Health	Vancouver Police Department
Island Health	Victoria Police Department
	WorkSafeBC

* There was an effort to include representatives from all major stakeholder groups, however inevitably, not all invitees were available to attend therefore certain stakeholder groups were underrepresented.





DTES, Vancouver

For more information, contact:

**BC Centre for Disease Control Harm Reduction Program
655 West 12th Avenue, Vancouver, BC. V5Z 4R4**

harmreduction@bccdc.ca

<http://www.bccdc.ca/our-services/programs/harm-reduction>

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