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THE OPIOID CRISIS

THE NEED FOR TREATMENT ON DEMAND

REVIEW AND RECOMMENDATIONS | MAY 2017



VANCOUVER POLICE DEPARTMENT | *Beyond the Call*

FENTANYL

CAN BE DEADLY WHEN CUT WITH THE DRUGS YOU'RE TAKING

KNOW YOUR SOURCE? **BE DRUG SMART**

KNOW**YOUR**SOURCE.CA



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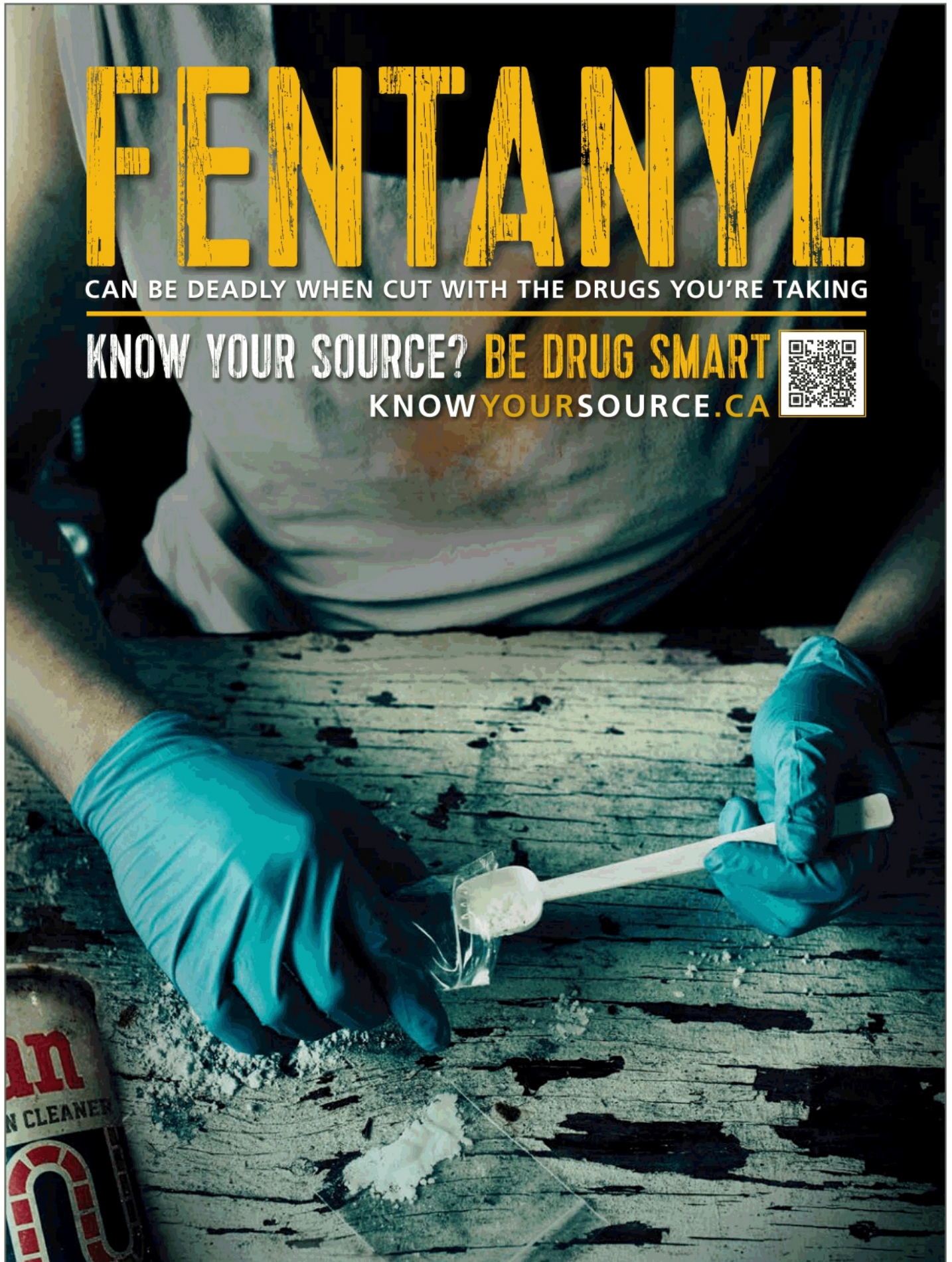
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EXECUTIVE SUMMARY

On April 14, 2016, British Columbia's Provincial Health Officer, Dr. Perry Kendall, declared the opioid crisis a public health emergency in B.C. In 2016, 931 British Columbians died from overdoses – 216 of these overdose deaths were in Vancouver. Fentanyl was detected in approximately 60% of those deaths (Coroners Service, 2017). The number of calls for service for Vancouver Fire and Rescue Services and the BC Ambulance Service have increased dramatically. In 2015, the agencies responded to 14,863 calls (combined). In 2016, this number rose to 23,987.

The crisis is continuing in 2017: by the end of March there had already been 347 overdose deaths in B.C. As high as these numbers are, there is evidence that overdoses are under-reported. Recent data from the Canadian Centre on Substance Abuse (2017) showed that between 2013 and 2016, up to 65% of individuals who were trained to administer naloxone (not including first responders and health officials) did not call 911.

IN PERSPECTIVE:

- In 2016, 931 British Columbians died from overdoses.
- Each year, about 600 British Columbians die from suicide.
- In 2015, 300 British Columbians died in motor vehicle accidents.
- In 2015, 95 British Columbians died due to homicides.
- Each year, 54 British Columbians, on average, die due to impaired driving.

China is the main source of supply for the fentanyl that flows into Canada, the United States, and Mexico (Drug Enforcement Administration, 2016). Sales of fentanyl have become widely available on the Internet.

Fentanyl is a less costly synthetic opioid being used by drug traffickers to boost their profits, and as a cheaper alternative to heroin. Fentanyl has been detected in all illicit drugs now, with the exception of marijuana.

There has been insufficient attention and funding for substance abuse treatment for many years. The opioid crisis has served to focus attention on the underfunding of addiction treatment that has contributed to the current crisis. The lack of evidence-based addiction treatment services contributes to a broad range of health and community harms that extend well beyond fatal overdoses. These harms can be prevented by investment in addiction care.

The results of numerous addiction research initiatives suggest that the provision of evidence-based addiction treatment, including opioid agonist therapy, where appropriate, can significantly mitigate risk and harm, facilitate addiction management, and contribute to overcoming addiction. It has been estimated by the U.S. National Institute of Drug Abuse (NIDA) that for every dollar invested in treatment, up to twelve dollars may be saved in health care and criminal justice costs (National Institute of Drug Abuse, n.d.).

The federal and provincial governments have dedicated additional funding to the opioid crisis. However, there is more work to do.

Based on the available research and in consultation with addictions specialists in B.C., the Vancouver Police Department (VPD) recommends the following:

1. Expand federal and provincial government support and accountability.

This support is required to enact an emergency response that is in keeping with the scale of the problem. The development of a functioning system for addiction prevention and care has long been neglected. The federal and provincial governments

should assign professionals to provide oversight and coordination of the efforts of various agencies working to address the crisis. Expanded support should include a full governance and accountability structure with real-time data analysis. It should foster structured communication with stakeholders and partners.

2. Expand and provide more funding for evidence-based addiction treatment, including opioid-assisted therapy¹ programs.

Opioid assisted therapy programs that provide people with substance use disorder with a range of effective opioid medications should be made immediately available in therapeutic and supported settings. The goal of this recommendation is to give addicted persons a “clean” opioid (with known contents) for their addiction and prevent them from contributing to the organized and disorganized crime-fuelled drug market through the purchase and use of contaminated street drugs.

3. Create a system for immediate evidence-based addiction treatment and concurrent mental health crisis intervention and support.

This should involve the opening/re-opening of in-patient beds for severe cases and the creation of sufficient community addiction and mental health services to support out-patients upon discharge from in-patient environments.

This must include a system to enable first responders or addicted persons to immediately gain access to assessment and evidence-based treatment. This should include withdrawal management and acute addiction treatment intake centres where first responders could transport those seeking treatment, or where

addicted persons themselves could go for immediate treatment.

4. Address the lack of health care information to allow for the creation of data-driven strategies.

Remarkably, unlike other areas of health care, there are glaring gaps in health information when it comes to addiction care. The lack of health informatics creates a situation where policy-makers do not have the information needed to address system gaps and other problems. This crucial information and data gap must be addressed.

5. Increase public awareness to support prevention through education – in line with the prevention and treatment pillars of the Four Pillars Drug Strategy.

It is necessary to increase awareness about overdose symptoms with more messaging in high visibility areas where drug consumption is likely. There also needs to be more education for students – elementary through post-secondary – about the dangers of opioid use, overdose prevention, and responses to overdoses. The development and delivery of this information should be coordinated across the province to ensure students in all areas of B.C. are receiving this information.

Establishing a national and provincial continuum of care and necessary systems requires resources. Financial, community, public safety, and public health gains can be made by acting with urgency and implementing the required substance abuse care structures. Providing timely and accessible evidence-based addiction treatment can reduce morbidity, mortality, crime, and health care costs across Canada. Maintaining the existing ineffective system is no longer an option.

¹This document uses the term opioid assisted therapy. Other terms (e.g., drug substitution) are common; professional guidelines reference opioid agonist therapy.

BACKGROUND: THE RISE OF OPIOID ABUSE

Opioids have a long history in Canada as pain management drugs. Some of the most common forms include fentanyl, hydromorphone, hydrocodone, morphine, methadone, meperidine, oxycodone, and codeine (Canadian Centre for Substance Abuse, 2013). Generally, low doses of opioids help reduce pain and a person's emotional response to pain. Despite the short-term pain-relieving benefits, the long-term effects are a cause for concern nationally at a public health level and for individual users. Long-term use can permanently damage a user's physiology and increase risk for other infections and diseases (Canadian Centre for Substance Abuse, 2013).

While opioids are prescribed by physicians for their pain-relieving properties, they may also put the user at risk for addiction. According to the Canadian Centre on Substance Abuse, "between 2005 and 2009, there were 815 deaths related to fentanyl, hydromorphone, morphine and oxycodone" in the province (2013). The rise of OxyContin in early 1992 created a mass market for opioids. Both legitimate patients and abusers were introduced to a new kind of product that had not been prevalent before. Despite the initial beliefs and claims that it was less addictive, many people moved from legitimate use, to dependence, and then abuse. With that, the illicit marketplace for stronger and cheaper alternatives greatly expanded. The misuse of opioid products containing oxycodone and hydrocodone increased, including the use of brands such as OxyContin, Vicodin, Percocet, and Lortab.

In 2012, OxyContin was removed from the marketplace and replaced with a new formulation marketed as more difficult to manipulate for misuse and abuse. This occurred

shortly before the patent protection on OxyContin was to expire. The removal of OxyContin from the Canadian marketplace left the abusers, and the patients who had become addicted to it, in search of a replacement. For many, that replacement was heroin.

Since then, the seizure by the VPD of synthetic opioids, including fentanyl, has risen steeply. Fentanyl is a powerful synthetic opioid analgesic that is similar to morphine, but more potent. It is now the fourth most analyzed drug in samples submitted to Health Canada (as of September 2016).

NEWER OPIOID ANALOGUES

FENTANYL

The Canadian Public Health Association defines fentanyl as a synthetic opioid pain reliever that shares similarities with other opioids such as morphine. However, a key difference between the two drugs is that fentanyl is approximately 50 to 100 times more powerful (Govindaraj, 2016). This drug was introduced to help people suffering from terminal pain. However, it has since then been used to treat less-severe pain (Govindaraj, 2016). It has also been used to treat patients with chronic pain who are physically tolerant to other opioids. When prescribed by a physician, fentanyl is often administered via injection or transdermal patch.

The majority of fentanyl associated with the opioid crisis is produced in clandestine labs, primarily in China, where the precursors to create fentanyl are unregulated. Large amounts of fentanyl are produced or purchased by drug traffickers. It is mixed with a number of illicit street drugs to increase the high and expand profits or, sold alone as a cheaper alternative to heroin.

CARFENTANIL

Carfentanil is one of the most potent opioids used commercially. It was first synthesized by a team of chemists at Janssen Pharmaceutical in 1974. This drug is approximately 10,000 times stronger than morphine and 100 times stronger than fentanyl (National Center for Biotechnology Information, n.d.). It was marketed under the name “Wildnil” and was only intended for use on large animals as a tranquilizer (National Center for Biotechnology Information, n.d.). Carfentanil is often used to sedate elephants. Elephants weigh between 5,000 and 14,000 pounds (the average adult male weighs 195 pounds).

In a nationwide warning to the public and law enforcement agencies, the United States Drug Enforcement Administration noted that carfentanil and fentanyl can come in several forms, including powder, blotter paper, tablets, and spray. Both can be absorbed through accidental inhalation of airborne powder (Drug Enforcement Administration, 2016).

Carfentanil was first detected in Vancouver in September 2016. In November, the first overdose in Vancouver occurred that could definitively be attributed to carfentanil. Since then, it has been detected in other situations. For example, VPD undercover officers purchased what they believed to be heroin, but after analysis, was confirmed to be carfentanil.

FENTANYL AND OVERDOSES

Illicit drug users are generally unaware if the heroin they are about to consume is laced with fentanyl. When they inject their standard dose of heroin, they may inadvertently consume a lethal amount of fentanyl. While drug dealers combine fentanyl with an illicit street drug to improve potency and increase profit, the lack of any “quality control” fails to ensure that a lethal amount of fentanyl has not been introduced.

For those intentionally seeking fentanyl, almost all fentanyl introduced to the illicit drug market is made in clandestine labs. This fentanyl is less pure than the pharmaceutical version and users have no way of determining the actual quantity in their supply. Those who are not seeking fentanyl, but other illicit drugs, such as cocaine, heroin, or methamphetamine, have no way of knowing if their drugs contain fentanyl or the quantity.

The estimated lethal dose of fentanyl for humans is two milligrams. The estimated lethal dose for carfentanil is 20 micrograms (a microgram is 1/1000 of a milligram). A typical business card weighs one gram. If a business card were torn into 1,000 pieces, the equivalent of two of those pieces of fentanyl could be fatal if it were ingested, inhaled, or absorbed through the skin.

THE FLOW OF FENTANYL INTO CANADA

THE PRIMARY SOURCE: CHINA

China is the main source of supply for illicit fentanyl that flows into Canada, the United States, and Mexico. China is reported not to have a fentanyl consumption issue (Drug Enforcement Administration, 2016).

Normally, fentanyl (in powder form) and pill presses are shipped to Canada via mail. Drug traffickers often mix the fentanyl with heroin, which is sold as heroin. Alternatively, the fentanyl is pressed into pills and sold in the drug market (e.g., into counterfeit prescription pills) (Drug Enforcement Administration, 2016).

Quality control is overlooked in favor of greater profits. Heroin may be combined with fentanyl at the source or smuggled into Canada and mixed again several times by various levels of traffickers – all to increase their profits. The end-user has no way of knowing what they are actually consuming or the quantity of other drugs, such as fentanyl, that are in their illicit drugs. The illicit drug supply has become contaminated as a result.

ENTRY INTO CANADA

Illegitimate suppliers in China have recognized that the Canada Border Services Agency (CBSA) is unable to monitor or search every package shipped into Canada. Further, pursuant to Section 99(2) of the Customs Act, the CBSA is not permitted to search packages that weigh less than 30 grams, without written consent of either the sender or the receiver. If fentanyl is being sent via mail with deadly dosages (which may be less than 30 grams), CBSA is currently unable to halt the entry of those envelopes (Canada Border Services Agency, 2008).

As a result, fentanyl has become widely available on the Internet. The drugs can be ordered online and then shipped to Canada in small- to medium-sized packages. There are currently provisions contained within Bill C-37 that would provide the CBSA with increased powers of search to close this loophole and would prohibit the unregistered importation of pill presses (House of Commons, 2016). Bill C-37 is currently in the third reading in the Senate.

THE OPIOID CRISIS IN BRITISH COLUMBIA

On April 14, 2016, B.C.'s Provincial Health Officer, Dr. Perry Kendall, declared the opioid crisis a public health emergency in B.C. In 2016, 931 British Columbians died from overdoses. There were 216 deaths in Vancouver alone. Fentanyl was detected in approximately 60% of the deaths in B.C. in 2016 (Coroners Service, 2017). The illicit overdose death rate in 2016 is an 80% increase over 2015, when 513 British Columbians died of overdoses. Fentanyl was detected in approximately 30% of the 2015 cases (Coroners Service, 2017). At the end of March 2017, there had been 347 overdose deaths in B.C.

Overdose fatalities are now the leading cause of unnatural deaths in B.C., and are increasing nationally as the spread of opioid analogues moves east from Western Canada.

Fentanyl is not solely restricted to being combined with heroin. It has been detected in every illicit drug tested by Health Canada except marijuana. As a result, overdose deaths are not confined to individuals who have addictions – occasional and first-time experimenters now risk death every time they use illicit drugs.

From 1999 to 2012, the number of overdose deaths each year in B.C. ranged between 172 and 294. The overdose death rates began steadily climbing after 2012 (depicted in Figure 1 below).

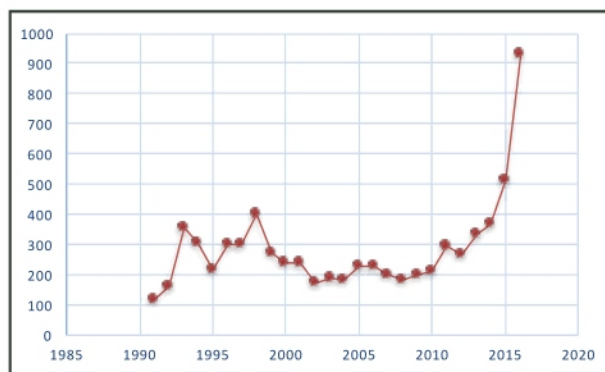


FIGURE 1. OVERDOSE DEATHS 1991-2016 (RETRIEVED FROM BC CORONERS SERVICE)

The following heat maps (Figure 2 and Figure 3) from the BC Centre for Disease Control (2017) compare, by region, deaths from illicit drug overdoses in 2012 to 2016.

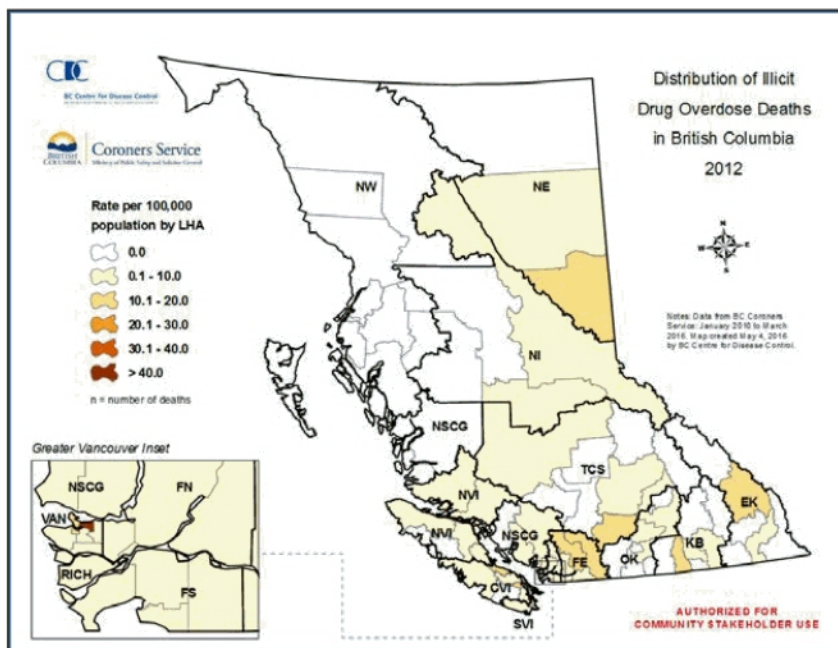


FIGURE 2. DISTRIBUTION OF OVERDOSE DEATHS IN 2012

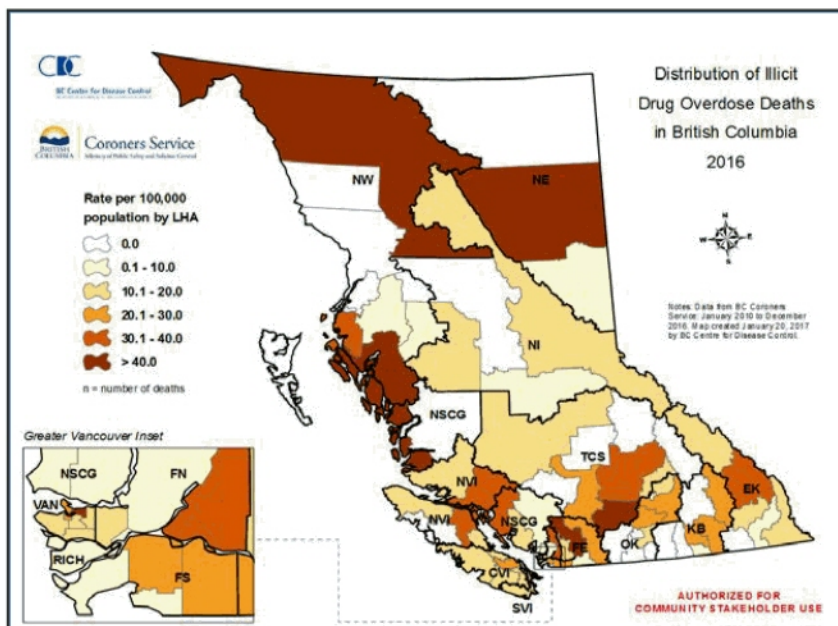


FIGURE 3. DISTRIBUTION OF OVERDOSE DEATHS IN 2016

IMPACT ON COMMUNITIES AND FIRST RESPONDERS

IMPACT ON COMMUNITIES

There is a misperception that opioid deaths are relegated primarily to individuals with substance dependency issues. The addition of fentanyl into other illicit drugs, such as cocaine, gamma-hydroxybutyrate (GHB), and ecstasy (3, 4-methylenedioxy-methamphetamine or MDMA), is exposing recreational users and young people experimenting with party drugs to the same risk of death as addicted persons.

The Downtown Eastside (DTES) of Vancouver has been hit particularly hard. It is a small community with a large number of individuals with substance dependency issues. The close-knit community has many outreach and community groups which have developed strong ties with the residents. Many outreach and community workers and residents are now grieving the death of someone they knew and cared for.

Many community groups and providers have instituted services to provide naloxone² intervention in their buildings and to the larger community. Paid workers and volunteers are regularly providing lifesaving first aid to those who overdose. The longer-term adverse psychological and emotional impact of the crisis on these people will only be seen in the coming years. Unlike professional first responders, these individuals sometimes lack institutional support systems for emotional and mental health, and are often left to deal with the psychological impact on their own.

Several managed housing buildings providing housing to the most vulnerable residents of the DTES, have turned rooms into monitored consumption sites for building residents.

Vancouver Coastal Health (VCH) responded by placing a mobile medical unit (MMU) into the DTES at a cost of about \$10,000 per day. This mobile emergency room was previously used for the 2010 Olympics. It is staffed by specialist physicians and nurses who provide immediate lifesaving intervention for people who overdose. Every overdose victim is provided options for treatment, although immediate access to long-term treatment and support is in very short supply. The services will continue at the newly opened Connections Clinic at 623 Powell Street, which is a step in the right direction.

VCH has also recently opened five overdose prevention sites in Vancouver, where addicted persons may consume illicit drugs with staff present to intervene if an overdose occurs. There have been no deaths at these sites. Between December 8, 2016, and February 19, 2017, there were more than 20,000 visits to these five sites and 202 overdoses were reversed.

The long-term impacts to survivors, their families, caregivers, and the economy will only be realized in the coming years. Overdose victims who manage to survive, can sustain irreparable brain injuries due to oxygen deprivation during their overdose. These injuries can be life-altering and may require lifelong care.

²Naloxone (also known as Narcan®) is a medication called an “opioid antagonist” used to counter the effects of opioid overdose, for example morphine and heroin overdose. Specifically, naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.

IMPACT ON FIRST RESPONDERS

Paramedics, firefighters, and police officers are often the first to respond to an overdose. The current crisis and volume of overdose calls has significantly impacted response times for first responders and has reduced service levels for others in need. It has also negatively impacted the mental health and emotional well-being of first responders, who have experienced stress, anxiety and “compassion fatigue” – a helplessness feeling that they are not making a difference (Britten, 2017).

Figure 4 shows how the opioid crisis has increased the number of calls for service for Vancouver Fire and Rescue Services (VFRS) and the BC Ambulance Service (BCAS) in the last two years. In 2015, VFRS responded to 2,600 overdose calls in Vancouver. In 2016, the number of calls almost doubled to 4,712. In 2015, BCAS attended 12,263 suspected overdose and poisoning events in B.C. (3,055 were in Vancouver). In 2016, this number rose to 19,275 (5,944 occurred in Vancouver). As high as these numbers are, there is evidence that overdoses are under-reported. Recent data from the Canadian Centre on Substance Abuse (2017) showed that between 2013 and 2016, up to 65% of individuals who were trained to administer naloxone (not including first responders and health officials) did not call 911.

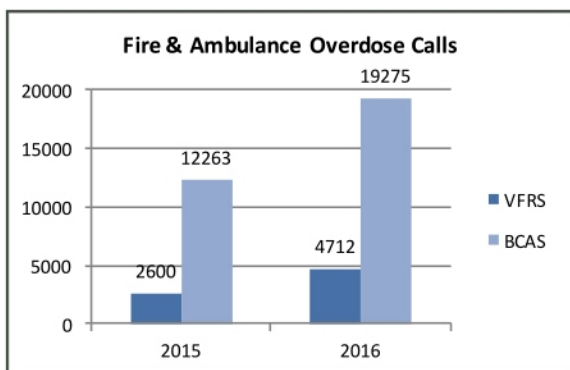


FIGURE 4. VFRS & BCAS OVERDOSE CALLS FOR SERVICE 2015 - 2016

FRONT-LINE FRUSTRATIONS

Constable Linda Malcolm, a 35-year member of the VPD, has worked with the most marginalized members of society in the DTES. Constable Malcolm has personally helped more than 50 people navigate the complex, disjointed, and under-resourced medical system to access withdrawal management or treatment.

Recently, Constable Malcolm was working with three women to secure help for their addictions. In one case, she was told that space in a treatment facility would not be available for nine days. She was able to find space for the other two women, but not in Vancouver.

The fact that the VPD has to source treatment outside of Metro Vancouver for residents of the largest city in the province is indicative of a fractured and under-resourced health care system.

In 2006, routine police response to overdose calls was recognized by the VPD as a barrier for people seeking help. It was apparent that people feared that asking for help would lead to police enforcement. As a result, the VPD implemented a new overdose policy: police officers are not dispatched to overdose calls unless the overdose results in death, the circumstances are suspicious, a safety concern exists for other first responders, or if it is an attempted suicide.

The presence of fentanyl poses an increased safety risk for police officers as they must deal with drug exhibits and enter buildings that may be contaminated with fentanyl. In B.C., as of March 2017, three police officers have been accidentally exposed to opioids during the course of their duties. They were administered naloxone to counter the effects of the substances and prevent an overdose. In December 2016, a VPD Community Safety member was exposed to an unknown substance while handling drug exhibits and was taken to the hospital. The member did not require the administration of naloxone. However, the emergency room physician attributed the symptoms to opioid exposure.

In September 2016, the VPD initiated a naloxone training program to mitigate the risk to members. Since that time, 870 members have been trained and equipped to administer intra-nasal naloxone.

Police officers regularly deal with individuals with addictions and recreational drug users. In unique communities such as the DTES, people often turn to the VPD for help. Frequently, officers face frustration when a drug-user finally agrees to treatment, but they don't have immediate access to resources or a coordinated health care system to turn to.

EXAMINING SOLUTIONS

WHAT IS WORKING ELSEWHERE? THE ANGEL PROGRAM

In the United States, the fentanyl crisis began on the East Coast. Several agencies initiated innovative strategies to reduce the overdose rates. In 2015, the Gloucester Police Department (Massachusetts) implemented the ANGEL program and placed almost 400 individuals into treatment in its first year of operation, thanks to a partnership with a local treatment centre (Gloucester Police Department, 2017). Under the program, when an addict asks a police officer for help getting into treatment, access is immediate. The innovative program saw addicted persons voluntarily reach out to the police for assistance. The fact that the State of Massachusetts mandates funding for drug treatment ensures sufficient treatment beds and immediate access.

The ANGEL program was reviewed by the Boston Medical Center and Boston University's School of Public Health. This study found that the program provided individuals with treatment at a rate of 95% while similar hospital-based initiatives provided assistance at a rate of only 50 to 60%. This successful initiative has been replicated by more than 150 police departments in 28 states since its inception (Gloucester Police Department, 2017). The key to the program's success is immediate access to appropriate treatment on demand.

OTHER INITIATIVES INSPIRED BY THE ANGEL PROGRAM

Other agencies across North America have adopted programs similar to the ANGEL program. A police department in North Carolina implemented the HOPE initiative. The HOPE initiative allows addicted individuals to

"...that drug-users could walk into the police station, hand over heroin, and walk out into treatment within hours – without arrest or charges. The concept of help rather than handcuffs became a national sensation."

FORMER CHIEF LEONARD CAMPANELLO
(MACQUARRIE, 2017)

turn in their drugs or paraphernalia without the fear of arrest, in exchange for treatment and resource options (Thomas, 2016).

The Hope Not Handcuffs program in Macomb County (Michigan) operates with a similar philosophy: individuals may walk into any police station in that county and ask for help. They are paired with volunteers from the community, while police arrange for accommodation at treatment centres.

LIVES AND COSTS CAN BE SAVED

Several studies have demonstrated that timely and appropriate addiction initiatives, including replacement therapy, may result in decreased adverse health risks to study participants. One such study, North America's first ever clinical trial of prescribed heroin, is the North American Opiate Medication Initiative (NAOMI). NAOMI examined how heroin-assisted therapy benefits persons with opioid dependency whom have not had success with other treatments. The findings show: "diacetylmorphine (DAM), administered under medical supervision, offered additional benefits over and above optimized

methadone maintenance therapy (MMT) alone for patients with opioid addiction who are refractory to treatment” (Providence Healthcare, 2016).

Furthermore, research findings have demonstrated that substitution therapy, with concurrent supports, is effective in the treatment of opioid addiction (e.g., Gossop, Marsden, & Stewart, 2006; Rehm, et al., 2001; Van Den et al., 2003). NIDA reports that for every dollar spent on treatment options, up to twelve dollars may be saved in health care and criminal justice costs. (National Institute of Drug Abuse, n.d.). In 2002, the cost to Canadians as a result of illicit drug abuse was estimated at \$8.2 billion (Canadian Centre for Substance Abuse, n.d.). Other studies have demonstrated that psychiatric symptoms may be reduced or eliminated as a result of concurrent drug abuse treatment (Gossop, Marsden & Stewart, 2006).

OVERCOMING BARRIERS TO ENFORCEMENT

Domestically, there has been increased scrutiny and pressure placed on China by the federal government and the Royal Canadian Mounted Police (RCMP) to stop the flow of fentanyl and other analogues into North America. Towards this, the RCMP and Chinese Ministry of Public Security announced joint efforts to disrupt the flow of fentanyl into Canada (British Columbia Ministry of Public Safety and Solicitor General, 2016).

The federal government has proposed legislation to provide CBSA with the authority to search packages entering Canada weighing less than 30 grams. Parliament is currently in the process of amending Bill C-37.

THE GAP

Many municipalities and agencies have adopted a common response to substance abuse– the Four Pillars Drug Strategy. This approach recognizes that four pillars support the response to substance abuse: prevention, harm reduction, enforcement, and treatment. All four pillars must work in concert for success.

The VPD released its drug policy in 2006. It was one of the first police agencies in Canada to adopt a drug policy and an overdose response policy that ascribes to the Four Pillars Drug Strategy.

The VPD has devoted significant resources to the enforcement pillar and supported the work done in the other pillars. Many agencies work proactively in promoting prevention. Harm reduction initiatives have received significant exposure and funding.

Effective treatments for substance abuse have been identified through many research studies. However, limited implementation and lack of funding and availability have resulted in treatment being one of the least supported of the pillars.

The federal and provincial governments have recently dedicated more funding to help with the crisis. However, there are insufficient organized treatment systems in place to enable first responders, or individuals with substance dependency themselves, to receive treatment immediately when it is sought. Delays in access to treatment results in missed opportunities to reduce harm, aid recovery, and prevent overdose deaths.

VPD INITIATIVES TO DATE

As the issues related to opioid abuse have grown, the VPD continues to actively participate and seek solutions outside of traditional policing initiatives, some of which include:

PARTNERING WITH OTHER AGENCIES

- The VPD is one of the original members of the Drug Overdose Alert Partnership (DOAP) – a group chaired by the BC Centre for Disease Control (BCCDC). DOAP is a multi-sectoral committee, established to prevent and reduce the harms associated with substance abuse. The committee identifies and disseminates timely information about harms related to substance abuse, including overdose and adverse reactions to contaminated products, maintains an informational website, and coordinates public health responses to emerging issues. Members of this committee include the VPD, all provincial health authorities, BC Coroners Service, RCMP, Victoria PD, Vancouver Area Network of Drug Users, and Health Canada.
- In October 2016, a meeting between the boards and the executive of the VPD and VCH was held to discuss treatment-on-demand services.
- In November 2016, the VPD and the Abbotsford Police Department were in attendance at the National Opioid Conference in Ottawa.
- The VPD Youth Services Section (YSS) works closely with the Vancouver School Board (VSB) and School Age Children and Youth (SACY). SACY is a substance use prevention initiative in VSB schools and the surrounding community, that works to prevent and delay substance use and reduce

substance use related problems. YSS has helped develop a fentanyl overdose pamphlet that will be distributed to VSB high school youth. In addition, members of VPD's School Liaison Unit have given fentanyl presentations to several VSB high schools. Members of the Youth Services Unit have given fentanyl presentations to elementary schools through the Police Athletic League program.

ADVOCACY

- In December 2015, the VPD formalized a desire to seek the creation of a treatment-on-demand system that would enable first responders, among others, to gain quick access to treatment for substance abusers. This approach is supported by the Vancouver Police Board.
- In January 2016, members of the VPD Executive met with representatives from BC Police Services to explain the need for treatment-on-demand in B.C.
- In February 2016, VPD Chief Constable Adam Palmer received support from members of the BC Association of Municipal Chiefs of Police (BCAMCP) for the VPD's efforts to continue lobbying the provincial government for treatment-on-demand.
- In July 2016, Premier Christy Clark announced that the Provincial Health Officer, Dr. Perry Kendall, and Assistant Deputy Minister, Clayton Pecknold, Director of Police Services Policing and Security Branch, would co-chair a new joint task force to provide advice to the provincial government on what could be done to prevent and respond to overdoses. VPD Deputy Chief Constable Laurence Rankin, is an active member of the committee.

- In December 2016, following nine overdose deaths in one day in Vancouver, Chief Palmer, in partnership with VFRS Chief John McKearney and Mayor Gregor Robertson, held a news conference calling for treatment-on-demand. They were supported by Dr. Bill MacEwan (Psychiatry, St. Paul's Hospital), Dr. Michael Krausz (Chair of Addiction Research UBC-Providence Health Care Leadership), Dr. Mark Tyndall (Executive Medical Director of BCCDC), and Dr. Kerry Jang.
- In January 2017, VPD Chief Adam Palmer and Deputy Chief Constable Steve Rai attended the Canadian Association of Chiefs of Police (CACP) President's Council meeting and advocated for the addition of the opioid crisis as a national priority for the CACP.

COMMUNITY ENGAGEMENT

- In June 2016, the VPD participated in the BCCDC's BC Overdose Action Exchange. Over 30 organizations came together to share their expertise and experience. Those directly impacted and threatened by overdose were also in attendance to provide their lived experiences. This action exchange collected submissions from participants to guide further discussion and action.
- In December 2016, more than 200 people participated in a public forum hosted by the mayor of Vancouver about the depth of the opioid crisis. Chief Palmer was a panellist, alongside other experts, like Dr. Patricia Daly, the Chief Medical Health Officer for VCH. Attendees learned from

the lived experiences of those most affected, including the parent of an overdose victim, an Aboriginal community member, a youth organization, and drug-user groups. Participants engaged in dialogue and identified key gaps and areas for action, including treatment-on-demand.

EDUCATION AND TRAINING

- In June 2016, two fentanyl workshops for first responders were developed and delivered by the VPD, RCMP, and Victoria PD, and hosted by the Justice Institute of BC. The workshops were delivered in Victoria and New Westminster and funded through the BC Civil Forfeiture Office (CFO). The workshops were the first to be held in Canada and generated significant interest with more than 100 in attendance in Victoria and almost 200 in New Westminster. Four more workshops are planned for May 2017 in New Westminster, Nanaimo, Kelowna, and Prince George. They will be funded by Police Services and the CFO.
- An officer safety concern warranted an immediate response to protect members from accidental exposure. The VPD developed a comprehensive training program for members to administer intranasal naloxone. In September 2016, the VPD began delivering the program to over 870 sworn, civilian, and jail members. The training continues in 2017 and the VPD has shared training materials with numerous police departments across Canada to expedite their training.

- The nursing staff at the Vancouver Jail determine upon intake if prisoners are at risk of overdose when they are released. Where indicated, the nursing staff will issue take-home naloxone kits to the prisoner upon release. This has been underway since October 2016.

PUBLIC AWARENESS

- To increase public safety, the VPD, in cooperation with health care partners at VCH and DOAP, proactively issues public warnings when unexpected drugs are detected or when an increase in overdoses is observed.
- The “Know Your Source” website is a VPD-led resource developed in partnership with the RCMP, BCAS, Fraser Health Authority, VCH, the Provincial Health Services Authority, and BCCDC. The website has been a key resource for the public for fentanyl awareness.
- The VPD has partnered with Odd Squad Productions Society (a charitable organization that takes a reality-based approach to address major social issues affecting the community). Odd Squad will produce a video for youth that focuses on education and prevention by highlighting the current crisis, its impacts on all walks of society, and the urgent need for treatment-on-demand.

ENFORCEMENT

Targeting organized crime groups (OCG) that manufacture and distribute fentanyl has been a public safety priority for the VPD since October 2014. The VPD Organized Crime Section (OCS) has conducted investigations that have targeted higher-level drug networks involved in the production and distribution of fentanyl. OCS continues to assist VPD’s Operations Division with targeted enforcement of street level drug networks. Additionally, OCS collaborates with the Combined Forces Special Enforcement Unit - BC (CFSEU) and the RCMP’s “E” Division Federal Serious and Organized Crime (FSOC) to combat the issue.

There are currently several enforcement projects underway, and some significant projects have been completed since 2014.

PROJECT TAINTED

Project Tainted (October 2014 to February 2015) targeted an OCG distributing fentanyl into the DTES and the Yukon. The project cost approximately \$450,000. Ten suspects were charged and most have already pleaded guilty. The project resulted in the seizure of:

- 25,000 fentanyl pills,
- 147,000 alprazolam pills,
- 9.5 kg of crack cocaine,
- 5 kg of powdered cocaine,
- 19.5 kg of marijuana,
- 1 kg methamphetamine,
- 3 kg of hashish,

- 0.5 kg of heroin,
- one pill press,
- four guns (3 handguns, 1 long gun),
- \$1.2 million in property,
- seven vehicles, and
- \$261,000 in cash.

PROJECT TROOPER

Project Trooper (October 2014 to March 2015), targeted an OCG distributing fentanyl in the DTES, Metro Vancouver, and Alberta. The project cost was approximately \$300,000. The eight-month investigation resulted in drug and weapon charges against six suspects, and the forfeiture of over \$3 million in property including a DTES single room occupancy (SRO) hotel. The arrests and executions of eight search warrants resulted in the seizure of:

- 25,000 fentanyl pills,
- 20.5 kg of cocaine,
- 12.2 kg of methamphetamine,
- 1.6 kg of heroin,
- 228 kg of phenacetin,
- 12 guns (6 handguns, 2 shotguns, 4 rifles),
- \$570,000 in cash, and
- eight vehicles.

PROJECT BREAKOUT

Project Breakout (December 2016 to February 2017) resulted in the execution of ten search warrants. The investigation is ongoing and charges are pending against six individuals. Seizures included:

- 70 gold and silver bars,
- three vehicles,
- \$90,000 in cash, and
- several kilograms of drugs (including fentanyl and heroin).

SAVING LIVES: TREATMENT ON DEMAND

The VPD recognizes that our expertise lies in public safety and not in addiction treatment. However, we cannot arrest our way out of the opioid crisis. As first responders, we routinely come across individuals who require addiction care but have nowhere to turn. First responders are uniquely positioned to help refer individuals to treatment services. Unfortunately, there is a lack of services that are immediately accessible. This usually means that the cycle of addiction and crime continues.

We are seeing the effects of the opioid crisis firsthand in the neighborhoods we serve and feel an ethical obligation to call for change. We have developed partnerships with many physicians and addiction experts to work towards a solution for this crisis.

As a result of insufficient funding and a lack of coordination for substance abuse treatment, everyone pays in the form of “downstream” medical and mental health costs, and there continue to be community concerns about crime and other challenges. The mental health consequences of untreated addiction often cost much more than providing substance abuse care. Further, the medical consequences can be a significant cost in the form of avoidable HIV and hepatitis C infections, and brain injuries from non-fatal overdoses.

It is through the information gleaned from partnerships and from experience on the front-line, that the VPD is proposing a number of initiatives to mitigate the impacts of the opioid crisis. These recommendations are based, in part, on the insight and research conducted by Dr. Kerry Jang, Dr. Michael Krausz, Dr. Bill MacEwan, Dr. Mark Tyndall, and other senior medical professionals, as well as numerous research studies. This position is further informed by the outcomes of the BC Overdose Action Exchange. B.C.’s Provincial Health Officer, Dr. Perry Kendall, has also provided his insight and review of these recommendations.

RECOMMENDATIONS

1. Expand federal and provincial government support and accountability.

This support is required to enact an emergency response that is in keeping with the scale of the problem. The development of a functioning system for addiction prevention and care has long been neglected. The federal and provincial governments should assign point people to provide oversight and coordination of the efforts of various agencies working to address the crisis. Expanded support should include a full governance and accountability structure with real-time data and analysis. It should foster structured communication with stakeholders and partners. It may also include dedicated projects aimed at addressing the health and social consequences of the opioid crisis and the long-standing limitations of the substance abuse treatment system.

2. Expand and provide more funding for evidence-based addiction treatment, including opioid-assisted therapy programs.

Opioid assisted therapy programs that provide addicted persons with opioid medications must be made immediately and easily accessible in therapeutic and supported settings. The goal of this recommendation is to give addicted persons a “clean opioid” (with known contents) for their addiction and to prevent addicted persons from contributing to the organized and disorganized crime-fuelled drug market through purchasing and using contaminated street drugs. While not nearly adequate in capacity, the Crosstown Clinic (which has treatment capacity for about 150 individuals) and Connections

Clinic that opened in March 2017 (Vancouver Coastal Health, 2016), are examples of progressive programs.

Immediately needed initiatives will require funding for medical staff to witness injections and funding for physicians. Support is needed from the federal and provincial governments to permit the wide use of new effective substitution drugs, such as slow release morphine, hydromorphone, methadone, extended release naltrexone (Vivitrol), and diacetylmorphine.

These services must also be integrated into the full spectrum of recovery-oriented services to ultimately help individuals stop using drugs altogether. This will require expanding addiction recovery programs and ensuring these programs are linked with the above models of care.

3. Create a system for immediate evidence-based addiction treatment and concurrent mental health crisis intervention and support.

- a. This should involve the opening/re-opening of in-patient beds for severe cases and the creation of sufficient community addiction and mental health services. These services are required to support out-patients and related care upon discharge from in-patient environments.
- b. This must include a 24/7 system to enable first responders or addicted persons to immediately gain access to assessment and evidence-based treatment. This should include withdrawal management and acute addiction treatment intake centres where first responders can transport those seeking treatment, or

where addicted persons can attend themselves for immediate addiction treatment-on-demand. An example of this is in Seattle, at the Crisis Solutions Center. This program provides rapid stabilization, treatment, and referrals for up to 46 individuals at a time (DESC, n.d.).

- c. Care models aimed at supporting acute addiction care through to recovery must be urgently expanded. These require after-care post-withdrawal management, such as mental health treatment and supports, and recovery services to be integrated into opioid agonist therapy and other treatment programs. This will require supportive recovery housing and longer-term publicly-funded addiction treatment bed capacity to be urgently expanded.

4. Address the lack of health care information to allow the creation of data-driven strategies.

Remarkably, unlike most areas of health care, there are glaring gaps in health information when it comes to addiction care. The lack of health informatics creates a situation where policy-makers do not always have the information needed to address system gaps and other problems. To address these gaps, a number of strategies are urgently required:

- a. Given that withdrawal management and acute addiction treatment programs need to be expanded and are often a first point of contact for persons struggling with addiction, there is a need for the creation of a province-wide information

system for tracking wait-lists. There must be evidence-based metrics for linking individuals seeking help with withdrawal management to ongoing evidence-based addiction care. The provincial government must create data systems to inform policies which immediately address the revolving door whereby individuals wait, sometimes weeks, to get access to withdrawal management programs, only to be discharged without being linked to ongoing addiction treatment.

- b. Supportive recovery housing and longer-term publicly-funded addiction treatment beds must be urgently expanded. Therefore, data to provide information about standards and outcomes from these programs must be immediately addressed by developing systems to ensure the health care system has the necessary data to provide quality care.
- c. It is necessary to create a clinical system to allow for assertive outreach (e.g., post-non-fatal overdose or presentation to the emergency department) to link at-risk individuals to addiction care after acute presentation. With a view to providing timely addiction care, anonymized data should be shared publicly and in real-time with all partners – front line workers, non-profits, cities, and police. This will enable each stakeholder to implement responses to the risk factors within their control or influence.
- d. The development of drug testing and other metrics to inform the creation of an early warning system that will

assist with the early identification and detection of new toxic drugs entering the illicit market. The information should be disseminated widely. Those presenting negative health effects of toxic drugs should be offered evidence-based alternatives to reduce the size of the illicit drug market and improve public health.

- e. An accurate and comprehensive study of the actual population size of persons with opioid dependency for major cities across British Columbia and Canada.
- f. A review of the overdose crisis should be conducted by internationally recognized experts, for an independent gap analysis of the resources, response, and overall situation. An analysis of all of the 2016 data should be conducted with a national view to be used as a planning document.
- g. The introduction of mandatory data collection and documentation of all overdoses and related fatalities and reports out to the public monthly.

5. Increase public awareness to support prevention through education in line with the prevention and treatment pillars of the Four Pillars Drug Strategy.

The VPD supports increasing public awareness on not just the dangers of opioids, but also how to respond to and treat overdoses.

- a. Increase awareness about overdose symptoms with increased messaging in high visibility areas (e.g., shopping malls) and areas where drug consumption is likely (e.g., night clubs, washrooms). There is also a need to reach people who can't access traditional media or social media. This may require the use of new and innovative systems and channels.
- b. Provide education to universities and colleges about the dangers of fentanyl use, overdose prevention, and responses to overdoses.
- c. Expand drug prevention education to elementary, secondary, and post-secondary institutions. The development and delivery of this information should be coordinated across the province to ensure students in all areas of B.C. are receiving this information.

When police or first responders are approached, or when individuals with drug dependency issues self-present at hospitals seeking assistance, we must have an established, coordinated, and properly resourced system to help. It must provide managed withdrawal or treatment/recovery assistance that is immediately available. We require a long-term health strategy that does more than revive people temporarily with naloxone and send them back to the street to continue their addiction.

CONCLUSION

Whether directly through the loss of loved ones, or indirectly through the adverse impacts to their communities, British Columbians are experiencing the impacts of the opioid crisis. The proposed recommendations are intended to reduce this impact. The number of overdoses and deaths associated with opioid addiction is steadily increasing, and without significant intervention, they will continue to rise. If change is implemented to create an effective system of substance abuse care, not only will the current opioid crisis receive appropriate attention, but longstanding challenges related to untreated addiction may also be addressed.

Research has provided evidence-based options for treatment that reduce overdose deaths, reduce the negative impacts on communities, and reduce costs. However, without sufficient access to treatment-on-demand, these options cannot be implemented. Therefore, we must invest in creating effective addiction treatment and realize the widespread public safety and public health benefits that would result.

The VPD supports improved coordination and proper resourcing to ensure that appropriate treatment with ongoing support is available for every person with a substance use disorder who seeks it. We are calling for appropriate and research-based treatment-on-demand to help save lives.

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