QUESTIONS AND ANSWERS

CBC Forum

Overdose Prevention

January 30, 2017

Page 002 to/à Page 010

Withheld pursuant to/removed as

Copyright

Providence HEALTH CARE
How you want to be treated.

Crosstown Clinic Three-Year Plan

Presentation to VCH Senior Executive Team 09Jun15

Scott Harrison, PHC Program Director HIV/Urban Health
Andrew MacFarlane, VCH Regional Director, Mental Health & Addiction Services
Dr. Scott McDonald, PHC Lead Physician Crosstown Clinic
Dr. Ronald Joe, VCH Associate Medical Director Addictions Services
Dr. Evan Wood, VCH Program Medical Director and PHC Physician Program Director Addictions Services

Providence HEALTH CARE
How you want to be treated.

Agenda

1. Context: VCH's Addictions Continuum
2. Crosstown Clinic History and Current Status
3. VCH-PHC Recommended Crosstown Model
4. Crosstown Volumes and Attrition Rate
5. Funding
   - Clinic
   - Drugs
6. Recommendations for SET

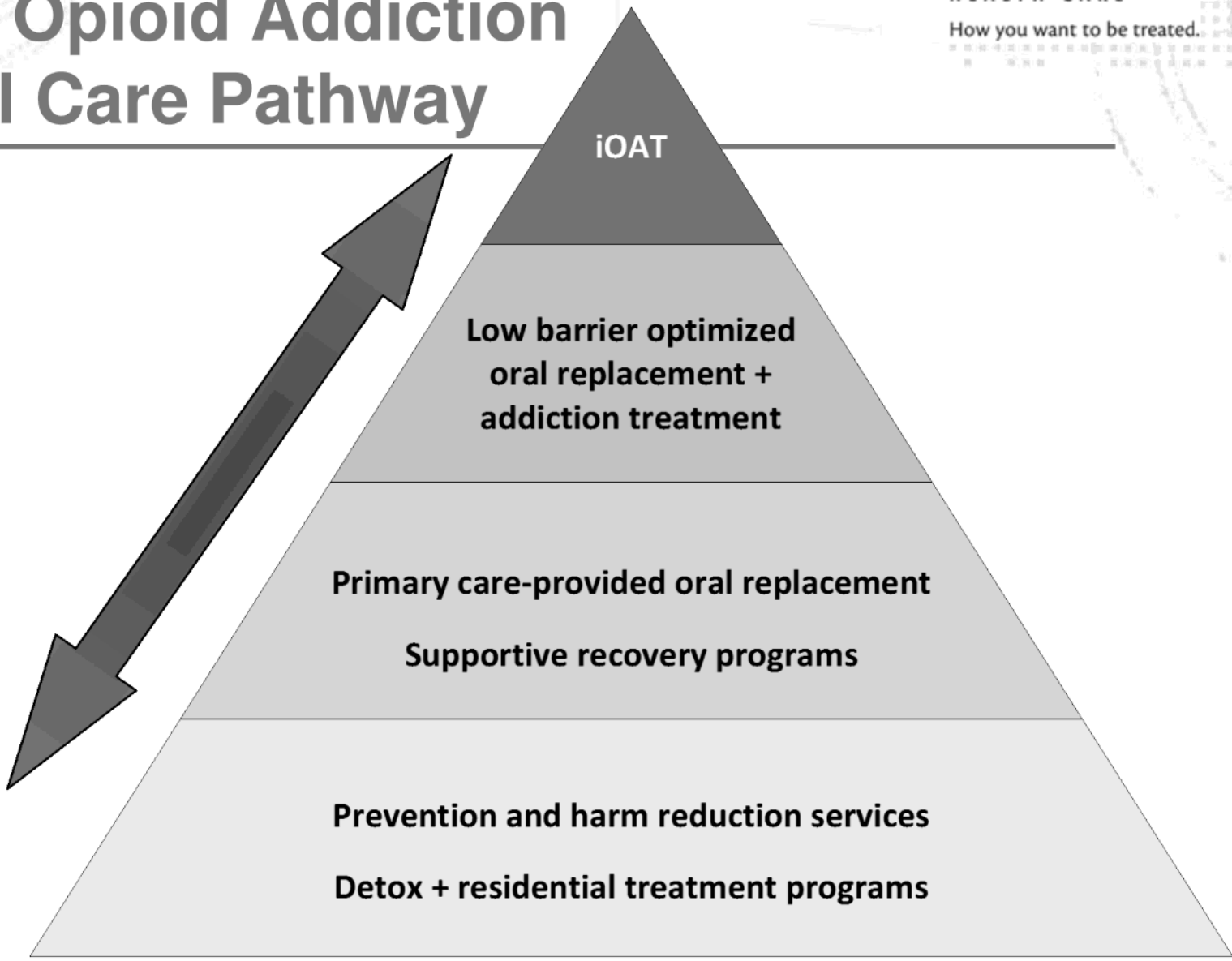
Providence HEALTH CARE
How you want to be treated.

1. Context: VCH Addictions Continuum

- VCH has requested a 3-year plan for Crosstown Clinic, including
  - Support for DTES 2nd Generation Strategy & Addictions continuum
  - Common PHC-VCH eligibility criteria & common pathway
  - Smooth transitions to less intensive care using pull strategy
  - Measurable outcomes
  - 3-year budget plan
- VCH DTES Second Generation Strategy (Feb 2015) commits to
  - ***Rec. 3*** *– invest in care models – including…addictions – that provide an [integrated] range of services, … e.g.* ***low-barrier*** *environments*
  - ***Rec. 11*** *– continue to support research and work with academic and government partners to build the case for* ***medicalized opiates*** *…*
  - ***Rec. 24*** *– establish a* ***continuum of care*** *for major aspects of the DTES health service system, such as … addiction services*

1. VCH Opioid Addiction Clinical Care Pathway

Providence HEALTH CARE
How you want to be treated.



Providence HEALTH CARE
How you want to be treated.

2. Crosstown Clinic History

- SALOME (Study to Assess Longer-term Opioid Medication Effectiveness) completed in September 2014 (202 patients)
  - First and only trial in the world to compare diacetylmorphine (DAM, heroin) to hydromorphone (HDM) for severely addicted heroin addicts who have not responded to traditional treatment (e.g., methadone)
  - Many trials (including NAOMI – SALOME's predecessor) have shown the benefit of DAM
  - DAM used extensively in Europe as treatment
- Results expected mid-2015
- Est. 190 (of the 202) study patients require ongoing treatment
  - Supreme Court decision allows access to DAM if individually approved through Health Canada's Special Access Program

Providence HEALTH CARE
How you want to be treated.

2. Crosstown Clinic Current Status

- Hydromorphone currently provided “off label” to patients who are not receiving DAM
- Currently (mid-May) 127 DAM + 23 HDM = 150 patients
- Physical constraints ++
  - Basement storage closed due to asbestos, inability to meet Health Canada Level 9 Security requirements, inadequate clean room, leaking ceiling over clean room, leaks and mold in vault, overcrowding, staff safety concerns….
  - Maximum capacity 160 patients in this location
  - Estimate 30 eligible patients unable to receive treatment until move to a new location

Providence HEALTH CARE
How you want to be treated.

3. Recommended Crosstown Model

- 2015/16: post-SALOME patients to max 160
  - Treat with DAM (preferred) or HDM (may change with study results)
  - Use standard VCH-PHC eligibility assessment tool, including
    - Ongoing illicit heroin (confirmed with urine drug screening)
    - Unable to tolerate less intensive treatment (methadone-Suboxone)
- Early 2016: move to new site
  - Purpose built with capacity for 200 patients
  - Add in remaining 30 post-SALOME patients
- 2016/17: as former SALOME patients transition out, fill Clinic to 200 with VCH patients as per VCH-PHC eligibility tool

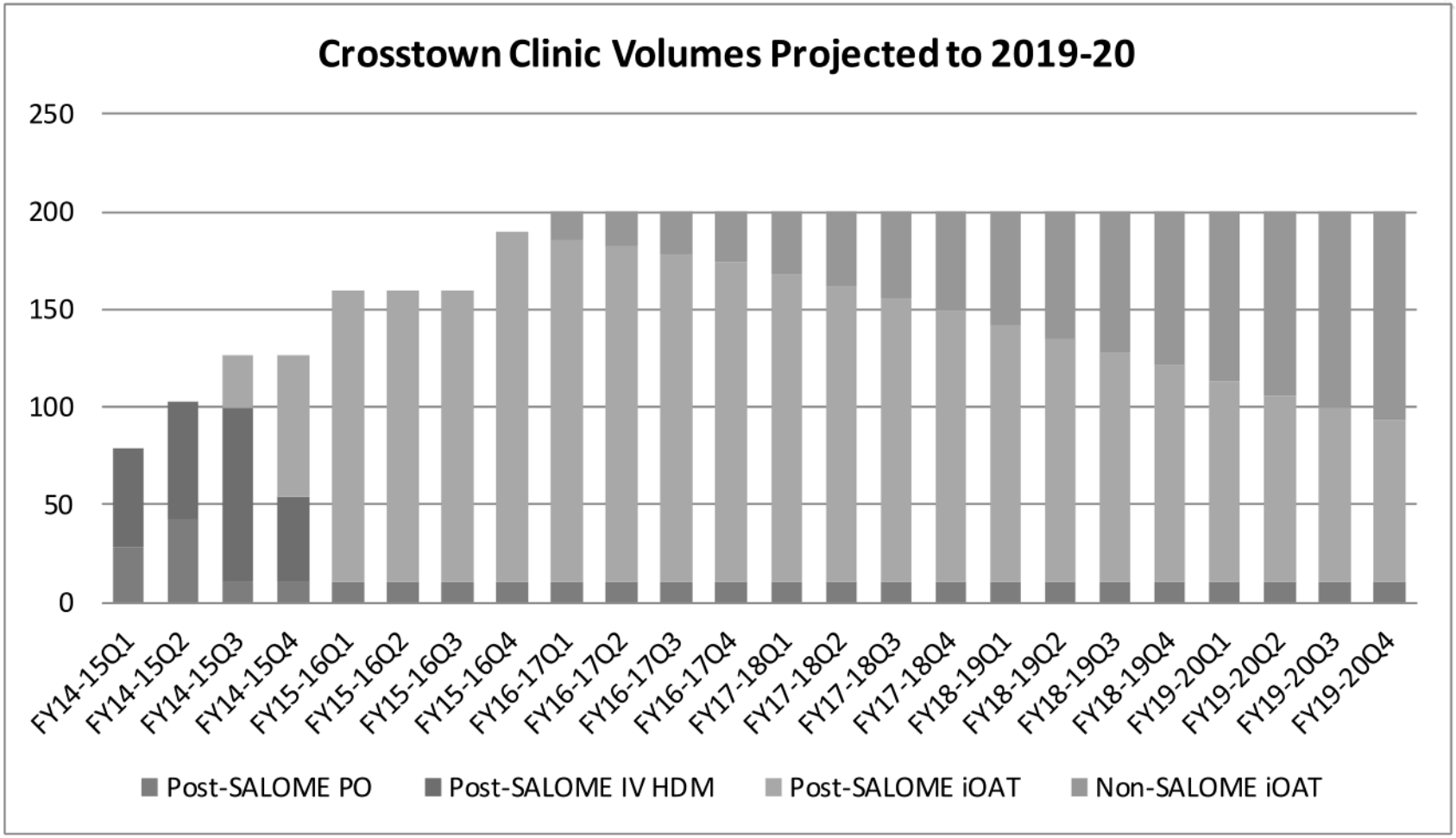
Providence HEALTH CARE
How you want to be treated.

3. Recommended Crosstown Model, ctd.

- Transitions per Opioid Addiction Transitional Care Pathway
  - VCH-PHC Opioid Dependence Clinical Guidelines under development (two-way iOAT⇦⇨Oral).
  - → less intensive treatment or less frequent drug administration
  - Transfer back in when relapses occur
  - VCH to work within Crosstown to facilitate ("pull") transitions
- Outcomes measurement
  - ↓ illicit drug use, confirmed by random urine drug screening
  - Continued evidence of engagement in treatment
  - Positive lifestyle outcomes per WHODAS or HoNOS tool

Providence HEALTH CARE
How you want to be treated.

4. Crosstown Volumes & Attrition Rate



Providence HEALTH CARE
How you want to be treated.

5. Funding – Clinic

THREE-YEAR FUNDING REQUIREMENT - CLINIC Operational Costs

	2015/16	2016/17	2017/18
Clinic Cost	$2,904,399	$2,943,438	$2,933,759
Less PHC Contribution	($1,304,399)	($1,343,438)	($1,333,759)
Total Required from VCH	**$1,600,000**	**$1,600,000**	**$1,600,000**

- If PHC and VCH maintain current funding levels ($1.3 + $1.6 m respectively), clinic costs for the next three years will be covered
- Capital $ needed for Clinic move rough estimate $1 million

Providence HEALTH CARE
How you want to be treated.

5. Funding – Drugs

THREE-YEAR FUNDING SHORTFALL - DRUGS

	2015/16	2016/17	2017/18
Average # pts. over the year	168	200	200
Drug Costs*	$2,326,382	$2,789,257	$2,789,257
Less MOH Drug Funding	($1,094,789)	($0)	($0)
Total Shortfall	**$1,231,593**	**$2,789,257**	**$2,789,257**

** Costs for 2016/17 & 2017/18 based on 190 IV DAM + 10 oral HDM = 200 patients*

- MOH funding $2.17 m confirmed starting Apr. 2014, based on former HDM pricing and forecasted 125-patient volume
- Intended to last through Dec. 2015, then re-assess
- $ will run out by Sept 2015, due to ↑ volumes and ↑ price
  - Short $1.2 million this FY and $2.8 m annually thereafter
  - MOH will not fund 2015/16 Q3 shortfall of $600K

Providence HEALTH CARE
How you want to be treated.

6. Recommendations for SET

1. SET endorse the model for Crosstown, as a resource for:

   (a) post-SALOME pts. and (b) future VCH patients (max. 200 total)

2. PHC and VCH widely promote the transition from research to evidence-based care, and

   continue to support addictions research, care, teaching & innovation

3. PHC and VCH continue to fund the clinic at $1.3m and $1.6m per annum, respectively

4. VCH fund $600K drug expense gap for Q3 2015/16 (one-time)

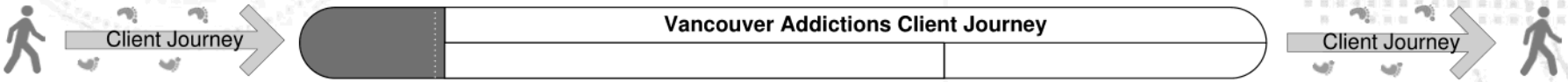
5. PHC, with VCH support, continue to work with MOH to fund drug costs for 2016 & beyond

Providence HEALTH CARE
How you want to be treated.

Additional Background Slide

1. VCH Addictions Continuum

Providence HEALTH CARE
How you want to be treated.



Prevention

- primary prevention & health promotion
- IEC - information, education and communication
- addiction diagnosis and linkage to care
- prevention of addiction-related diseases
- early substance use treatment, mental health and social support
- programs to minimize harm for people living with addictions and their families
- social mobilization

Harm Reducing Services

- supervised injection sites
- needle exchange
- safer crack use services
- take home naloxone program
- peer programs
- outreach services

Low Barrier Treatment

- injectable opiate-assisted therapy (iOAT)
- low barrier methadone / Suboxone
- rapid access addictions clinic
- SPH Urban Health Unit

DTES 2nd Generation Identified Gaps:

low-barrier, culturally safe treatment e.g.

iOAT clinics, fast-track / low-barrier / drop-in addictions clinics

Treatment & Supportive Recovery

- Onsite
- community methadone
- navigation & orientation
- education & groups
- counseling
- bio-psychosocial supports
- self-management programs
- information referral services
- outreach workers
- market housing subsidies
- subsidized housing - HIV+
- housing / tenant workers
- shelters/temporary accommodation
- stabilization beds
- income supports
- S/R contracted providers
- immigration & legal services
- other supports

Community

- 12-step programs
- faith-based programs
- aboriginal community programs
- medication management
- counselling
- primary care

NEWS CONFERENCE –
Providence Health Care Unveils SALOME Research Study Results

Room 1500, Conference Centre, St. Paul's Hospital (SPH), 1081 Burrard Street (Enter through SPH Main Entrance. Greeters will be on hand to direct media to conference room. News Conference signage will be available. Or follow the Blue Lines on the floor to the Conference Centre)

Date: Wednesday, April 6, 2016 **Event Time:** 9:30 a.m.
Pre-Brief Time: 9:00 a.m.

Time	Event Itinerary
7:30 a.m.	Event set up begins.
9:00 – 9:28 a.m.	**Pre-Brief** – For all stage guests. Facilitated by Justin Karasick and Ann Gibbon, PHC Communications & Public Affairs **Location** – Conference Room # 6, Providence Building, St. Paul's Hospital **Stage Guests:** • Scott Harrison, Director Urban Health & HIV/AIDS • Dr. Eugenia Oviedo-Joekes, SALOME Principal Investigator • Dr. Scott MacDonald, Lead Physician, Providence Crosstown Clinic (where SALOME trial is conducted) • SALOME Patients Lynda and Russell TBD.
9:28 – 9:30 a.m.	Stage guests proceed to Room 1500 in the Conference Centre and sit at table in the order identified above. (2 minutes)
9:30 – 9:37 a.m.	**EVENT BEGINS** • **Emcee Scott Harrison, Director Urban Health & HIV/AIDS, Providence Health Care - St. Paul's,** steps to podium, gives words of welcome. Introduces himself/stage guests. • Announces that the results of the SALOME study are in, provides brief background on the trials. • **Introduces video about the study. Video starts, lasts 2-3 minutes. Lights dim.** • Lights up; Scott invites **Dr. Oviedo-Joekes** to speak.

	(7 minutes for all of the above)

9:37 - 9.42 a.m.	**Dr. Oviedo-Joekes** speaks (5 minutes)
9:42 – 9.43 a.m.	**Scott Harrison** invites Dr. Scott MacDonald to speak. (1 minute)
9:43- 9:46 a.m.	**Dr. Scott MacDonald** speaks • Talks about the SALOME trial, his patients and how they did in the study. • Describes hydromorphone as one more tool in the toolkit for heroin treatment. (3 minutes)
9:46 – 9:47 a.m.	**Emcee Scott Harrison** thanks Dr. MacDonald. Invites SALOME patient(s) to speak.
9:47 – 9:52 a.m.	**SALOME patients** speak • Talk about their personal experience/history as chronic heroin users and then as SALOME participants. • How the study and the medications have helped them – life before/after participating in the trials. • Talk about holistic support the clinic provided. (5 minutes total)
9:52 – 9:53 a.m.	**Emcee Scott Harrison** thanks SALOME patient(s). Wraps up; thanks guests. Explains the media Q&A portion will start; introduces PHC Media Relations Spokesperson (Ann hands things over for moderating media Q&A. (1 minute)
9:53 – 9.54 a.m.	Ann explain the rules (Qs from the room first; from the phone lines after; reporters are to ID themselves). (2 minutes) Media Q&A of panel members starts.
9.54 – 10:19 a.m.	Question Period (up to 25 minutes)
10:19 – 10:20 a.m.	**Question Period ends. Ann thanks everyone;** **remind media of 11.30 availability with cameras at Crosstown Clinic; provide address. They announce there**

	will now be one-on-one availability with speakers.
10:20-10:35-ish a.m.	**One-on-Ones. EVENT ENDS.**
11:30-12:30	**Media tours of the Crosstown Clinic.** Dr. Scott MacDonald and Julie Foreman to give tour. Justin to be on site to help coordinate.

- The perspectives of people with lived experience with substance use are essential to informing our response to this crisis – that is why since 2011 they have been partners in the Drug Overdose and Alert Partnership. This Partnership feeds into the work of the Joint Task Force on Overdose Response.
- B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes immediate short-term harm-reduction actions and emergency response measures, including:
    - significantly expanding access to naloxone - more than 22,000 take-home naloxone kits have been dispensed,
    - implementing 20 overdose prevention sites in the hardest-hit areas of the province;
    - working to increase the number of supervised consumption services - VCH, Island Health and FH have submitted applications – as well as;
    - providing added resources to BC Emergency Health Services.
- We are also taking action to provide better supports for treatment and recovery, including:
    - opening 60 additional substance use treatment beds and 50 outpatient treatment spaces, in addition to the promised 500 new addictions treatment beds (almost 400 open to date, with the remainder to be open by March 31st).

  - expanding access to opioid substitution therapies like Suboxone, and
  - supporting the work of the BC Centre on Substance Use to improve the overall system of care.

- While we view this crisis as a significant health issue, it is multifaceted and requires action on many fronts.
- To this end, law enforcement is working at all levels of government – federal, provincial and municipal – on measures to intercept and block the supply of toxic drugs.
- We have also been working with the federal government on a number of fronts, and appreciate their efforts on this file -- including expediting Bill C-37, which will simplify and streamline applications for supervised consumption sites, regulating precursors to fentanyl, improving border controls and negotiating an agreement with China to stop the flow of illegal fentanyl into Canada.
- The new federal funding of $65 million for a national strategy, as well as a further $10 million to support B.C.'s response, shows they continue to take this issue seriously
- We are fighting to save lives from the opioid epidemic sweeping B.C., and we will continue to work with our partners across the health and safety sectors to combat this crisis.

If asked about prescription heroin or alternative treatments:

- B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment.

- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.
- The experience with injectable hydromorphone treatment through the Crosstown Clinic is supporting this work.
- The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

If asked about supervised consumption services

- Budget 2017 provides for an additional $5 million to continue support for the ongoing work of the Joint Task Force on Overdose Response, and the federal government last week committed to provide B.C. with $10 million to help combat the crisis.
- While the exact allocation of the funds is still being determined, they will help support strategies identified by the task force, which include opening additional supervised consumption

services – as well as expanding rapid access to opioid substitution treatment; better mental and emotional support for people who work on the front lines; continued expansion of access to naloxone; and targeted law enforcement activities.

- Island Health has submitted an application for a supervised consumption service in Victoria, and is actively working on a second application for another site in Victoria.
- In the meantime, Island Health has also opened four overdose prevention sites, to give people using drugs a safer place where they can be monitored for overdose.
- We absolutely agree that supervised consumption sites are important health services that have been proven to reduce harm by providing safe, clean and supervised environments for drug use in high-risk areas.
- These sites prevent overdose deaths and injuries, reduce the risk of HIV and hepatitis transmission, connect people to treatment and recovery resources and decrease the use of police, ambulance and emergency medical services.
- In fact, Vancouver's Insite has never had a fatal overdose with more than three million injections, and there were no deaths at supervised consumption sites or drug overdose prevention sites in 2016.
- That is why in response to the opioid overdose crisis, all Health Authorities in B.C. are actively working on applications for new supervised consumption services.
- To date, Vancouver Coastal Health has submitted two applications for supervised consumption services in Vancouver,

Island Health has submitted one application for Victoria and Fraser Health has submitted two applications for Surrey.

- No decisions have been made by Health Canada to approve new applications at this time but we will continue to work with communities to keep them informed as this work progresses.

If asked about wait times for access to methadone – as noted in a recent Times Colonist article?

- Regional health authorities have been working with the Ministry to identify the gaps in community access to opioid replacement therapies.
- The province has allocated another $5 million to support the work of the task force in Budget 2017, and the federal government just announced they would provide $10 million to assist the province with its response to the overdose crisis.
- We expect that the Joint Task Force will recommend allocating a significant portion of the newly available funding to addressing these gaps in access to the continuum of addictions care.
- That includes continued expansion of access to Suboxone, which is the main recommended treatment for opioid addiction, as well as methadone for those for whom it is suitable.
- The province has been working to significantly expand access to opioid substitution therapies – in particular Suboxone – over the past year.
- As of February 1, 2017, PharmaCare is now providing 100% no-cost coverage for Suboxone and methadone to lower-income British Columbians.

- Health authorities have also been working to expand access to these opioid substitution treatments and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing these treatments.
- Since Oct. 1, 2016, the BCCSU has hosted six training sessions throughout the province with more than 550 health-care providers on how best to treat patients who struggle with opioid addiction – in particular how to safely and appropriately prescribe Suboxone.
- In addition, the College of Registered Nurses of BC is working to expand scope of practice for nurse practitioners providing addictions care to include the provision of Suboxone and methadone treatment.
- The number of people started on Suboxone or its generic version under PharmaCare increased from an average of about 127 per month in 2015 to a monthly average of 284 people in 2016.
- The number of people started on methadone was relatively constant in 2015 and 2016 at about 200 people per month.
- In 2015, 2,960 British Columbians were covered under PharmaCare for Suboxone, and in 2016, that number increased to 5,576.
- The number of patients on methadone under PharmaCare in 2015 was 16,698, increasing to 17,515 in 2016.
- Over the past five years, the number of people who received PharmaCare coverage for these important medications has

increased significantly. Since 2011, almost 7,000 more patients received methadone or Suboxone under PharmaCare.

If asked about access to methadone in Victoria:

- In Island Health's service area, there are 82 physicians who are licenced to prescribe methadone.
- All physicians in the province are able to administer and prescribe Suboxone once they have taken the online training.
- In Victoria, a new Rapid Access Addictions Clinic service is now open and providing opioid substitution therapy, which includes methadone or Suboxone treatment.
- The Rapid Access Addictions Clinic is working closely with Emergency Departments and Psychiatric Emergency Services to make sure those who are started on Suboxone have immediate follow up treatment and care.
- The clinic is also working in partnership with the Cool Aid Clinic, the Victoria Youth Clinic, Pandora Clinic and the Umbrella Society (peer support) to ensure clients get the care they need for their ongoing opioid use.
- The Rapid Access Addictions Clinic is currently accepting referrals through Island Health's Substance Use Intake as well as for follow up treatment from hospital.
- The clinic is open seven hours per week and is supported by family practitioners, a nurse and health consultant.

Overdose State of Emergency

- The opioid overdose crisis is having devastating effects on families across Canada – and British Columbia in particular.
- There were 914 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015. 116 people died last month – every one of them someone's mother, father, sister, brother, son or daughter.
- We are taking this crisis very seriously.
- The province has earmarked about $100 million for measures that will help combat the crisis.
- The perspectives of people with lived experience with substance use are essential to informing our response to this crisis – that is why since 2011 they have been partners in the Drug Overdose and Alert Partnership. This Partnership feeds into the work of the Joint Task Force on Overdose Response.
- B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes immediate short-term harm-reduction actions and emergency response measures, including:
    - significantly expanding access to naloxone - more than 22,000 take-home naloxone kits have been dispensed,
    - implementing 20 overdose prevention sites in the hardest-hit areas of the province;
    - working to increase the number of supervised consumption services - VCH, Island Health and FH have submitted applications – as well as;

  - providing added resources to BC Emergency Health Services.

- We are also taking action to provide better supports for treatment and recovery, including:
  - opening 60 additional substance use treatment beds and 50 outpatient treatment spaces, in addition to the promised 500 new addictions treatment beds (almost 400 open to date, with the remainder to be open by March 31st).
  - expanding access to opioid substitution therapies like Suboxone, and
  - supporting the work of the BC Centre on Substance Use to improve the overall system of care.
- While we view this crisis as a significant health issue, it is multifaceted and requires action on many fronts.
- To this end, law enforcement is working at all levels of government – federal, provincial and municipal – on measures to intercept and block the supply of toxic drugs.
- We have also been working with the federal government on a number of fronts, and appreciate their efforts on this file -- including expediting Bill C-37, which will simplify and streamline applications for supervised consumption sites, regulating precursors to fentanyl, improving border controls and negotiating an agreement with China to stop the flow of illegal fentanyl into Canada.

- The new federal funding of $65 million for a national strategy, as well as a further $10 million to support B.C.'s response, shows they continue to take this issue seriously
- We are fighting to save lives from the opioid epidemic sweeping B.C., and we will continue to work with our partners across the health and safety sectors to combat this crisis.

If asked about prescription heroin or alternative treatments:

- B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment.
- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.
- The experience with injectable hydromorphone treatment through the Crosstown Clinic is supporting this work.
- The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.

- The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

If asked about supervised consumption services

- Budget 2017 provides for an additional $5 million to continue support for the ongoing work of the Joint Task Force on Overdose Response, and the federal government last week committed to provide B.C. with $10 million to help combat the crisis.
- While the exact allocation of the funds is still being determined, they will help support strategies identified by the task force, which include opening additional supervised consumption services – as well as expanding rapid access to opioid substitution treatment; better mental and emotional support for people who work on the front lines; continued expansion of access to naloxone; and targeted law enforcement activities.
- Island Health has submitted an application for a supervised consumption service in Victoria, and is actively working on a second application for another site in Victoria.
- In the meantime, Island Health has also opened four overdose prevention sites, to give people using drugs a safer place where they can be monitored for overdose.
- We absolutely agree that supervised consumption sites are important health services that have been proven to reduce harm by providing safe, clean and supervised environments for drug use in high-risk areas.

- These sites prevent overdose deaths and injuries, reduce the risk of HIV and hepatitis transmission, connect people to treatment and recovery resources and decrease the use of police, ambulance and emergency medical services.
- In fact, Vancouver's Insite has never had a fatal overdose with more than three million injections, and there were no deaths at supervised consumption sites or drug overdose prevention sites in 2016.
- That is why in response to the opioid overdose crisis, all Health Authorities in B.C. are actively working on applications for new supervised consumption services.
- To date, Vancouver Coastal Health has submitted two applications for supervised consumption services in Vancouver, Island Health has submitted one application for Victoria and Fraser Health has submitted two applications for Surrey.
- No decisions have been made by Health Canada to approve new applications at this time but we will continue to work with communities to keep them informed as this work progresses.

If asked about wait times for access to methadone – as noted in a recent Times Colonist article?

- Regional health authorities have been working with the Ministry to identify the gaps in community access to opioid replacement therapies.
- The province has allocated another $5 million to support the work of the task force in Budget 2017, and the federal government just announced they would provide $10 million to assist the province with its response to the overdose crisis.

- We expect that the Joint Task Force will recommend allocating a significant portion of the newly available funding to addressing these gaps in access to the continuum of addictions care.
- That includes continued expansion of access to Suboxone, which is the main recommended treatment for opioid addiction, as well as methadone for those for whom it is suitable.
- The province has been working to significantly expand access to opioid substitution therapies – in particular Suboxone – over the past year.
- As of February 1, 2017, PharmaCare is now providing 100% no-cost coverage for Suboxone and methadone to lower-income British Columbians.
- Health authorities have also been working to expand access to these opioid substitution treatments and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing these treatments.
- Since Oct. 1, 2016, the BCCSU has hosted six training sessions throughout the province with more than 550 health-care providers on how best to treat patients who struggle with opioid addiction – in particular how to safely and appropriately prescribe Suboxone.
- In addition, the College of Registered Nurses of BC is working to expand scope of practice for nurse practitioners providing addictions care to include the provision of Suboxone and methadone treatment.

- The number of people started on Suboxone or its generic version under PharmaCare increased from an average of about 127 per month in 2015 to a monthly average of 284 people in 2016.
- The number of people started on methadone was relatively constant in 2015 and 2016 at about 200 people per month.
- In 2015, 2,960 British Columbians were covered under PharmaCare for Suboxone, and in 2016, that number increased to 5,576.
- The number of patients on methadone under PharmaCare in 2015 was 16,698, increasing to 17,515 in 2016.
- Over the past five years, the number of people who received PharmaCare coverage for these important medications has increased significantly. Since 2011, almost 7,000 more patients received methadone or Suboxone under PharmaCare.

If asked about access to methadone in Victoria:

- In Island Health's service area, there are 82 physicians who are licenced to prescribe methadone.
- All physicians in the province are able to administer and prescribe Suboxone once they have taken the online training.
- In Victoria, a new Rapid Access Addictions Clinic service is now open and providing opioid substitution therapy, which includes methadone or Suboxone treatment.

- The Rapid Access Addictions Clinic is working closely with Emergency Departments and Psychiatric Emergency Services to make sure those who are started on Suboxone have immediate follow up treatment and care.
- The clinic is also working in partnership with the Cool Aid Clinic, the Victoria Youth Clinic, Pandora Clinic and the Umbrella Society (peer support) to ensure clients get the care they need for their ongoing opioid use.
- The Rapid Access Addictions Clinic is currently accepting referrals through Island Health's Substance Use Intake as well as for follow up treatment from hospital.
- The clinic is open seven hours per week and is supported by family practitioners, a nurse and health consultant.

Overdose State of Emergency

- The opioid overdose crisis is having devastating effects on families across Canada – and British Columbia in particular.
- There were 922 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015. 116 people died last month – every one of them someone's mother, father, sister, brother, son or daughter.
- We are taking this crisis very seriously.
- The province has earmarked about $100 million for measures that will help combat the crisis.
- B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes immediate short-term harm-reduction actions and emergency response measures, including:
    - significantly expanding access to naloxone - more than 22,000 take-home naloxone kits have been dispensed,
    - implementing 20 overdose prevention sites in the hardest-hit areas of the province;
    - working to increase the number of supervised consumption services - VCH, Island Health and FH have submitted applications – as well as;
    - providing added resources to BC Emergency Health Services.
- We are also taking action to provide better supports for treatment and recovery, including:

  - opening 60 additional substance use treatment beds and 50 outpatient treatment spaces, in addition to the promised 500 new addictions treatment beds (almost 400 open to date, with the remainder to be open by March 31st).
  - expanding access to opioid substitution therapies like Suboxone, and
  - supporting the work of the BC Centre on Substance Use to improve the overall system of care.

- While we view this crisis as a significant health issue, it is multifaceted and requires action on many fronts.
- To this end, law enforcement is working at all levels of government – federal, provincial and municipal – on measures to intercept and block the supply of toxic drugs.
- We have also been working with the federal government on a number of fronts, and appreciate their efforts on this file -- including expediting Bill C-37, which will simplify and streamline applications for supervised consumption sites, regulating precursors to fentanyl, improving border controls and negotiating an agreement with China to stop the flow of illegal fentanyl into Canada.
- The new federal funding of $65 million for a national strategy, as well as a further $10 million to support B.C.’s response, shows they continue to take this issue seriously
- We are fighting to save lives from the opioid epidemic sweeping B.C., and we will continue to work with our partners across the health and safety sectors to combat this crisis.

If asked about prescription heroin or alternative treatments:

- B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment.
- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.
- The experience with injectable hydromorphone treatment through the Crosstown Clinic is supporting this work.
- The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

If asked about Overdose Prevent Sites in Surrey

- The opioid overdose crisis is having devastating effects on families across Canada,
- With the surge of overdose events in November, all health authorities promptly implemented a number of strategies including overdose prevention sites.
- As of Jan. 25, 2017, there are 20 overdose prevention sites currently open in the hardest-hit areas of the province.
- This includes two in Surrey.
    - In addition to ones in Vancouver (5), Maple Ridge (2), Abbotsford (1), Langley (1), Victoria (4), Nanaimo (1) Kamloops (2), Kelowna (1) and Prince George (1).
- These are all locations that have been experiencing significant numbers of overdoses.
- Fraser Health's overdose deaths decreased the most in the latest coroner's report – 29 in January 2017 compared to 38 in December 2016.
- Each community across each health authority has a unique population with unique needs, and the community service providers that the health authorities partner with are different in each community – and each health authority has established emergency harm reduction measures in communities based on these factors, and they will look different community by community .

- The overdose prevention services they have are embedded in existing locations, like shelters, address the needs of the population in locations where they are already accessing those services.
- An overdose prevention site in one community may not look exactly the same as in another, but they are fulfilling the same function in a way that meets the needs of the people there.
- To connect with the segment of people who are consuming substances indoors, Fraser Health is enhancing its data collection and analysis, and is working on outreach strategies.

If asked why the Surrey overdose prevention sites do not have space where people can inject drugs, like other such sites in other health authorities:

- Each community across each health authority has a unique population with unique needs, and the community service providers that the health authorities partner with are different in each community.
- Each health authority has established emergency harm reduction measures in communities based on these factors, and they will look different community by community.
- No one is being turned away for using drugs at the Surrey overdose prevention sites.

If asked about supervised consumption services

- Budget 2017 provides for an additional $5 million to continue support for the ongoing work of the Joint Task Force on Overdose Response, and the federal government last week committed to provide B.C. with $10 million to help combat the crisis.
- While the exact allocation of the funds is still being determined, they will help support strategies identified by the task force, which include opening additional supervised consumption services – as well as expanding rapid access to opioid substitution treatment; better mental and emotional support for people who work on the front lines; continued expansion of access to naloxone; and targeted law enforcement activities.
- Supervised consumption sites are important health services that have been proven to reduce harm by providing safe, clean and supervised environments for drug use in high-risk areas.
- These sites prevent overdose deaths and injuries, reduce the risk of HIV and hepatitis transmission, connect people to treatment and recovery resources and decrease the use of police, ambulance and emergency medical services.
- In fact, Vancouver's Insite has never had a fatal overdose with more than three million injections, and there were no deaths at supervised consumption sites or drug overdose prevention sites in 2016.
- That is why in response to the opioid overdose crisis, all Health Authorities in B.C. are actively working on applications for new supervised consumption services.

- To date, Vancouver Coastal Health has submitted two applications for supervised consumption services in Vancouver, Island Health has submitted one application for Victoria – and is actively working on a second – and Fraser Health has submitted two applications for Surrey.
- In the meantime, health authorities have also opened 20 overdose prevention sites, to give people using drugs a safer place where they can be monitored for overdose.
- No decisions have been made by Health Canada to approve new applications at this time but we will continue to work with communities to keep them informed as this work progresses.

If asked about wait times for access to methadone – as noted in a recent Times Colonist article?

- Regional health authorities have been working with the Ministry to identify the gaps in community access to opioid replacement therapies.
- The province has allocated another $5 million to support the work of the task force in Budget 2017, and the federal government just announced they would provide $10 million to assist the province with its response to the overdose crisis.
- We expect that the Joint Task Force will recommend allocating a significant portion of the newly available funding to addressing these gaps in access to the continuum of addictions care.
- That includes continued expansion of access to Suboxone, which is the main recommended treatment for opioid addiction, as well as methadone for those for whom it is suitable.

- The province has been working to significantly expand access to opioid substitution therapies – in particular Suboxone – over the past year.
- As of February 1, 2017, PharmaCare is now providing 100% no-cost coverage for Suboxone and methadone to lower-income British Columbians.
- Health authorities have also been working to expand access to these opioid substitution treatments and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing these treatments.
- Since Oct. 1, 2016, the BCCSU has hosted six training sessions throughout the province with more than 550 health-care providers on how best to treat patients who struggle with opioid addiction – in particular how to safely and appropriately prescribe Suboxone.
- In addition, the College of Registered Nurses of BC is working to expand scope of practice for nurse practitioners providing addictions care to include the provision of Suboxone and methadone treatment.
- The number of people started on Suboxone or its generic version under PharmaCare increased from an average of about 127 per month in 2015 to a monthly average of 284 people in 2016.
- The number of people started on methadone was relatively constant in 2015 and 2016 at about 200 people per month.

- In 2015, 2,960 British Columbians were covered under PharmaCare for Suboxone, and in 2016, that number increased to 5,576.
- The number of patients on methadone under PharmaCare in 2015 was 16,698, increasing to 17,515 in 2016.
- Over the past five years, the number of people who received PharmaCare coverage for these important medications has increased significantly. Since 2011, almost 7,000 more patients received methadone or Suboxone under PharmaCare.

Overdose State of Emergency – UPDATED

- The opioid overdose crisis is having devastating effects on families across Canada – and British Columbia in particular.
- There were 922 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015. 116 people died last month – every one of them someone's mother, father, sister, brother, son or daughter.
- We are taking this crisis very seriously.
- The province has earmarked about $100 million for measures that will help combat the crisis.
- B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes immediate short-term harm-reduction actions and emergency response measures, including:
    - significantly expanding access to naloxone - more than 22,000 take-home naloxone kits have been dispensed,
    - implementing 20 overdose prevention sites in the hardest-hit areas of the province;
    - working to increase the number of supervised consumption services - VCH, Island Health and FH have submitted applications – as well as;
    - providing added resources to BC Emergency Health Services.
- We are also taking action to provide better supports for treatment and recovery, including:

  - opening 60 additional substance use treatment beds and 50 outpatient treatment spaces, in addition to the promised 500 new addictions treatment beds (almost 400 open to date, with the remainder to be open by March 31st).
  - expanding access to opioid substitution therapies like Suboxone, and
  - supporting the work of the BC Centre on Substance Use to improve the overall system of care.

- While we view this crisis as a significant health issue, it is multifaceted and requires action on many fronts.
- To this end, law enforcement is working at all levels of government – federal, provincial and municipal – on measures to intercept and block the supply of toxic drugs.
- We have also been working with the federal government on a number of fronts, and appreciate their efforts on this file -- including expediting Bill C-37, which will simplify and streamline applications for supervised consumption sites, regulating precursors to fentanyl, improving border controls and negotiating an agreement with China to stop the flow of illegal fentanyl into Canada.
- The new federal funding of $65 million for a national strategy, as well as a further $10 million to support B.C.’s response, shows they continue to take this issue seriously
- We are fighting to save lives from the opioid epidemic sweeping B.C., and we will continue to work with our partners across the health and safety sectors to combat this crisis.

If asked about prescription heroin or alternative treatments:

- B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment.
- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.
- The experience with injectable hydromorphone treatment through the Crosstown Clinic is supporting this work.
- The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

If asked why the Surrey overdose prevention sites do not have space where people can inject drugs, like other such sites in other health authorities:

- Each community across each health authority has a unique population with unique needs, and the community service providers that the health authorities partner with are different in each community.
- Each health authority has established emergency harm reduction measures in communities based on these factors, and they will look different community by community.
- No one is being turned away for using drugs at the Surrey overdose prevention sites.
- I have asked Fraser Health to look at whether or not the current model could be a barrier for people accessing overdose-prevention services and evaluate the effectiveness of the current harm-reduction sites.
- Fraser Health is enhancing its data collection and analysis, and is working on outreach strategies.
- We know there are supervised consumption sites that are being applied for, but until then, it is important that we make sure there are no barriers to people in Surrey.
- With the surge of overdose events in November, all health authorities promptly implemented a number of strategies including overdose prevention sites.

Hot Issues – February 28, 2017, 9:40 a.m.

- As of Jan. 25, 2017, there are 20 overdose prevention sites currently open in the hardest-hit areas of the province.
- This includes two in Surrey, in addition to ones in Vancouver (5), Maple Ridge (2), Abbotsford (1), Langley (1), Victoria (4), Nanaimo (1) Kamloops (2), Kelowna (1) and Prince George (1).
- These are all locations that have been experiencing significant numbers of overdoses.
- Fraser Health's overdose deaths decreased the most in the latest coroner's report – 29 in January 2017 compared to 38 in December 2016.

PHO Special Report – Opioid Subsituation Treament System Performance Measures

- The overdose crisis is a very complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm-reduction and addiction and recovery treatment, as well as legislation that crosses many jurisdictional boundaries.

- It is important to note that the opioid overdose crisis – declared in April 2016 – falls outside the reporting period of the BC Opioid Substitution Treatment System Performance Measures report.

- There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and buprenorphine/naloxone (brand name Suboxone).

- The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for up to 150 patients, providing injectable opioids i.e. diacetylmorphine and hydromorphone, under supervision.

- The BC Centre on Substance Use is working with addictions experts across B.C. on research, education and training and treatment guidelines to make sure substance use treatment for British Columbians is effective and evidence-based.

- The new provincial opioid use disorder guideline developed by addictions experts through the BC Centre on Substance Use provides an evidence-based approach to guide doctors and

nurse practitioners in treating patients suffering from opioid addiction.

- The newly-released opioid treatment guideline recommends Suboxone and methadone as first-line treatments – treatments that work well for the majority of patients.
- The BC Centre on Substance Use is also working to examine the role that additional treatments, such as injectable hydromorphone for those who have not responded to first-line treatment, might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations.
- At this time, we are focused on providing first-line opioid substitution therapies such as methadone and Suboxone and improving access to these.
- As of February 1, 2017, PharmaCare provides 100% coverage for buprenorphine/naloxone and methadone to lower-income British Columbians.
- Health authorities have also been working to expand access to these opioid substitution treatments in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.
- Since Oct. 1, 2016, the BCCSU has hosted 17 training sessions throughout the province with more than 800 health-care providers at 14 locations on how best to treat patients who

struggle with opioid use disorder – in particular how to safely and appropriately prescribe Suboxone.

Secondary:

- There were more than 900 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015 – every one of them someone's mother, father, sister, brother, son or daughter.
- B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes immediate short-term harm-reduction actions and emergency response measures, including:
- Significantly expanding access to naloxone and distributing more than 32,000 take-home naloxone kits,
- Implementing 20 overdose prevention sites in the hardest-hit areas of the province,
- Working to increase the number of supervised consumption services and
- Providing added resources to BC Emergency Health Services.
- We are also taking action to provide better supports for long-term treatment and recovery, including:
- Opening 60 additional substance use treatment beds and 50 outpatient treatment spaces. This is in addition to the promised

500 new substance use treatment beds – with almost 400 open to date and the remainder to be open by March 31st and

- Expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.
- As of February 1, 2017, PharmaCare is now providing 100% no-cost coverage for Suboxone and methadone to lower-income British Columbians.
- Health authorities have also been working to expand access to these opioid substitution treatments and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing these treatments.
- In addition, the College of Registered Nurses of BC is working to expand scope of practice for nurse practitioners providing addictions care to include the provision of Suboxone and methadone treatment.

If asked about prescription heroin:

- B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients.
- More work needs to be done to gain a better understanding of how the evidence supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.

- However, B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment due to a research clinical trial.
- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- The experience with injectable hydromorphone treatment through the Providence/VCH-operated Crosstown Clinic is supporting this work. The BC Centre on Substance Use and the Provincial Health Officer are also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.
- The Ministry of Health is reviewing any recommendations with health authorities and other stakeholders to prepare options for consideration.

Opioid Prescribing

- The Ministry is working with the BC Centre on Substance Use to ensure physicians have appropriate training and education on treating opioid use disorder, based on the latest evidence and best practices.
- In June 2016, the College of Physicians and Surgeons of BC released new standards and guidelines on Safe Prescribing of Drugs with Potential for Misuse/Diversion.
- The document reflects a minimum standard of professional behaviour and recommended course of action with respect to prescribing and monitoring patients on prescribed opioid medications.
- B.C. has one of the strongest prescription drug monitoring systems in Canada. This includes PharmaNet, a world class system that keeps track of prescription claims so prescribing patterns can be evaluated.
- Community doctors and nurse practitioners in B.C. can access PharmaNet by enrolling in a Ministry of Health service called Community Health Practice Access to PharmaNet.
- Doctors and nurse practitioners employed by Health Authorities may also access PharmaNet once approved by their administrator.
- The College of Physicians and Surgeons considers it best practice for physicians to check PharmaNet at the time of issuing a prescription for medication, including opioid therapy. In addition, a PharmaNet review is mandatory in walk-in clinics and methadone clinics.

- The Ministry of Health and the College of Physicians recognizes this is an area where we can make improvements and we are actively working together on developing a standard, which will require doctors to check PharmaNet before prescribing narcotics such as opioids.
- The College of Physicians and Surgeons of BC intends to consult with physicians on a proposed new standard on mandatory use of PharmaNet when prescribing opioids and other drugs that present a potential risk to patients.
- In addition to the standards and guidelines on safe prescribing, the College has existing guidelines on the treatment of opioid use disorder with Methodone and/or Buprenorphine/Naloxone. These guidelines will be in effect until June 5, 2017 when the new guideline from BCCSU comes into effect.
- The Coroners Service's also has a new investigation unit that will be doing more in-depth investigation into illicit drug overdoses from last year, including examining opioid prescription history, which will help inform the degree to which prescribing is a factor in the current crisis.

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE **Ministry: Health** **Date: March 22, 2017** **Minister Responsible: Terry Lake**	**Overdose Response: Alternative Opioid Substitution Treatments**

BACKGROUND REGARDING THE ISSUE:

- In April 2016, results of the ground-breaking Study to Access Longer-term Opioid Medication Effectiveness (SALOME) research showed that chronic heroin addiction has another effective treatment tool in hydromorphone (a licenced pain medication).
    - The study was led by researchers from Providence Health Care, the Centre for Health Evaluation and Outcome Sciences at St. Paul's Hospital, and the School of Population and Public Health at the University of British Columbia.
- While methadone and Suboxone are an effective treatment for many people with opioid addiction, they do not work for a proportion of people. Alternative treatments, like diacetylmorphine (medical-grade heroin) and hydromorphone (Dilaudid), may be a more successful treatment option in those cases.
- In September 2016, the federal government overturned a ban on physicians prescribing heroin, which had been imposed by the previous Conservative government. The federal health minister has since stated that provinces, including B.C., have not taken up this opportunity.
- On January 2017, a coroner's inquest recommended expansion of diacetylmorphine and hydromorphone treatment programs for chronic opioid users in B.C.
- On Feb. 7, 2017, the BC Centre on Substance Use (BCCSU) released a provincial clinical treatment guideline for opioid use disorder for B.C. physicians and nurse practitioners. The guideline will come into effect as of June 5, 2017, replacing the existing methadone and buprenorphine/naloxone guideline developed by the College of Physicians and Surgeons of BC. The BCCSU will take responsibility for the educational requirements needed to prescribe methadone currently provided by the College.
- The BCCSU clinical guideline calls for a stepped up and integrated approach to opioid use disorder treatment, which includes Suboxone (also known as buprenorphine/ naloxone) as the recommended first line of treatment, followed by methadone where appropriate. Both are oral treatments.
- The BCCSU guideline focuses on oral treatment options, for which B.C. has extensive experience in all health authorities, and does not recommend the injectable treatments of diacetylmorphine and hydromorphone. Only Vancouver Coastal currently has experience with injectable treatments and the associated infrastructure at this time, and their health authority-level guidelines do discuss injectable options.
- First line treatments used in BC and recommended in BCCSU:
    - Buprenorphine/naloxone (Suboxone and generics)
    - Methadone
- Also addressed in the BCCSU guideline

    - Oral morphine – Since November 2014, slow-release oral morphine (24-hour formulation, brand name Kadian) has been approved by Health Canada for the treatment of opioid use disorder. Limited preliminary evidence suggests slow-release oral morphine formulations prescribed as agonist treatment may provide similar benefits to methadone-based therapy. Health care providers who wish to prescribe slow-release (24-hour) oral morphine for the treatment for opioid use disorder should hold a valid federal Section 56 exemption from the Controlled Drugs and Substances Act to prescribe methadone, or consult a specialist or experienced prescriber prior to initiating treatment. Another option would be to consult the provincial Rapid Access to Consultative Expertise (RACE) line.
    - Oral naltrexone – the guideline suggests evidence on the effectiveness of this treatment remains weak. Currently, oral naltrexone is only eligible for BC PharmaCare coverage as a Limited Coverage Drug for the treatment of alcohol use disorder. It is currently off-label if prescribed for the treatment of opioid use disorder, and is not eligible for coverage.
- Alternative injectable treatment options currently used in B.C. only at Crosstown Clinic:
    - Hydromorphone – as opioid substitution therapy, this is currently considered an "off-label use" and as yet not an officially recognised treatment option
    - Diacetylmorphine – as opioid substitution therapy, this is currently considered an "off-label use" and as yet not an officially recognised treatment option
    - The BCCSU guideline states that while these are evidence-based treatments, they are outside the scope of the guideline, which focuses on oral medications.

ADVICE AND RECOMMENDED RESPONSE:

- **There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and buprenorphine/naloxone (brand name Suboxone).**
- **The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for up to 150 patients, providing injectable opioids i.e. diacetylmorphine and hydromorphone, under supervision.**
- **The BC Centre on Substance Use is working with addictions experts across B.C. on research, education and training and treatment guidelines to make sure substance use treatment for British Columbians is effective and evidence-based.**
- **The new provincial opioid use disorder guideline developed by addictions experts through the BC Centre on Substance Use provides an evidence-based approach to guide doctors and nurse practitioners in treating patients suffering from opioid addiction.**
- **The newly-released opioid treatment guideline recommends Suboxone and methadone as first-line treatments – treatments that work well for the majority of patients.**
- **The BC Centre on Substance Use is also working to examine the role that additional treatments, such as injectable hydromorphone for those who have not responded to first-line treatment, might play in our overall response.**

- **The Ministry of Health looks forward to receiving and reviewing those recommendations.**
- **At this time, we are focused on providing first-line opioid substitution therapies such as methadone and Suboxone and improving access to these.**
- **As of February 1, 2017, PharmaCare provides 100% coverage for buprenorphine/naloxone and methadone to lower-income British Columbians.**
- **Health authorities have also been working to expand access to these opioid substitution treatments in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.**
- **Since Oct. 1, 2016, the BCCSU has hosted 17 training sessions throughout the province with more than 1000 health-care providers at 14 locations on how best to treat patients who struggle with opioid use disorder – in particular how to safely and appropriately prescribe buprenorphine/naloxone.**

<u>If asked about Health Canada's amended legislation (Sept. 2016) to allow doctors the ability to apply to prescribe pharmaceutical-grade heroin:</u>

- **The amended federal legislation shows a willingness of the federal government to acknowledge that a range of treatment options need to be made available.**
- **Here in B.C. we support this approach, however more work needs to be done to gain a better understanding of how the evidence supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in the B.C. context.**

Communications Contact: Hannah Lawrie
Reviewer:
Program Area Contact:
File Created: Dec. 22, 2016; Feb. 8, 2017
File Updated: March 22, 2017

Minister's Office	Program Area	Deputy	HLTH Communications

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE **Ministry: Health** **Date: March 24, 2017** **Minister Responsible: Terry Lake**	**Overdose Crisis: B.C. Opioid Substitution Treatment Report**

BACKGROUND REGARDING THE ISSUE:

- On March 27 2017, the Office of the Provincial Health Officer (PHO) is releasing the BC Opioid Substitution Treatment System Performance Measures Report on B.C.'s opioid substitution treatment (OST) system.
- The report includes recent data on patient numbers, retention, hospitalization, and mortality, as well as pharmacist numbers, physician numbers, patient retention in treatment, and provincial expenditures for methadone and buprenorphine/naloxone (tradename Suboxone).
- Sources for the report include PharmaNet, Medical Services Plan Genesis, hospital discharge abstract database (DAD) and the HealthIdeas Client Registry.
- The report covers the years 2014/15 and 2015/16; however it is important to note that the opioid overdose public health emergency falls outside its reporting period.
- It is also important to note that during the reporting period, physicians still required authorization from the College of Physicians and Surgeons of British Columbia to prescribe buprenorphine/naloxone. Effective July 1, 2016, physicians no longer require an exemption to prescribe buprenorphine/naloxone (although it is still necessary for methadone prescribing).
- This is the fourth report from the PHO on BC's OST System and it shows that:
    - Between 2014/15 and 2015/16, the number of patients for the OST program increased from 17,765 to 19,057, or 7%. This is a 67% increase from 2009/10.
    - Between 2014/15 and 2015/16, the number of methadone maintenance treatment patients increased from 16,274 to 16,900, or 4%.
    - Between 2014/15 and 2015/16, the number of patients on buprenorphine/naloxone increased by 46%.
    - Most of the increase of OST patients is attributable to additional buprenorphine/naloxone patients rather than additional methadone patients.
    - There were 401 physicians prescribing OST in 2015/16, up from 379 the year before.
    - The number of pharmacies and pharmacists dispensing methadone or buprenorphine/naloxone for maintenance purposes has been increasing – from 2,184 in 2009/10 to 3,343 in 2015/16.
    - In 2015/16, the average cost of OST per patient was $3,041, a decrease in average cost of $146 per patient since 2009/10.
    - Dosing level seems to be a factor in retaining patients – the probability of a patient staying in treatment is the highest for patients taking at least 100 mg of methadone per day, and people who stay longer in OST generally have better

long-term health outcomes.

- In B.C., 32% of people are retained in methadone maintenance treatment after 12 months compared to 39-49% Ontario. Ontario published different retention rates for different geographic areas. A contributing factor in B.C.'s lower retention rate may be patients transitioning between methadone and buprenorphine/naloxone treatments, and patients transitioning in and out of hospitals or other institutions. Both of these situations may show as a discontinuation in treatment based on PharmaCare data.
- The average cost of hospitalization per patient on OST has mostly been declining since 2009/10 (from $1012 per patient in 2009/10 to $999 per patient in 2015/16).
- Mortality rates among OST patients have been consistent over the last several years, and are substantially lower than mortality rates among regular or dependent users of opioids such as heroin or illegally-acquired fentanyl.

ADVICE AND RECOMMENDED RESPONSE:

- **I'd like to thank Provincial Health Officer, Dr. Perry Kendall for this report. This data helps us understand what's working and what we need to improve on.**
- **It's very encouraging that BC's Opioid Substitution Treatment System is helping people, while saving health care dollars.**
- **This is part of our commitment to build a comprehensive system of mental health and substance use services across the province.**

If asked about the overdose crisis:

- **The overdose crisis is a very complex issue involving many factors, including housing, public safety, policing, border control, public health, harm-reduction, substance use disorder treatment and recovery, as well as legislation that crosses many jurisdictional boundaries.**
- **It is important to note that the opioid overdose crisis – declared in April 2016 – falls outside the reporting period of the BC Opioid Substitution Treatment System Performance Measures report.**
- **There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and buprenorphine/naloxone (brand name Suboxone).**
- **The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for up to 150 patients, providing injectable opioid substitution treatment i.e., diacetylmorphine and hydromorphone, under supervision.**
- **The BC Centre on Substance Use is working with addictions experts across B.C. on research, education and training and treatment guidelines to make sure substance use disorder treatment for British Columbians is effective and evidence-based.**
- **The new provincial opioid use disorder treatment guideline developed by addictions experts through the BC Centre on Substance Use provides an evidence-based approach to guide doctors and nurse practitioners in treating**

patients suffering from opioid use disorder.

- **The newly-released opioid treatment guideline recommends buprenorphine/naloxone and methadone as first-line treatments – treatments that work well for the majority of patients.**
- **The BC Centre on Substance Use is also working to examine the role that additional treatments, such as injectable hydromorphone for those who have not responded to first-line treatments, might play in our overall response.**
- **The Ministry of Health looks forward to receiving and reviewing the recommendations from the BC Centre on Substance Use on additional treatments.**
- **At this time, we are focused on providing first-line opioid substitution therapies such as methadone and buprenorphine/naloxone and improving access to these.**
- **As of February 1, 2017, PharmaCare provides 100% coverage for buprenorphine/naloxone and methadone to lower-income British Columbians.**
- **Health authorities have also been working to expand access to these opioid substitution treatments in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.**
- **Since Oct. 1, 2016, the BCCSU has hosted 17 training sessions throughout the province with more than 1000 health-care providers at 14 locations on how best to treat patients who struggle with opioid use disorder – in particular how to safely and appropriately prescribe buprenorphine/naloxone.**

Secondary:

- **There were more than 900 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015 – every one of them someone's mother, father, sister, brother, son or daughter.**
- **B.C. is taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.**
- **This includes immediate short-term harm-reduction actions and emergency response measures, including:**
    - **Significantly expanding access to naloxone and distributing more than 34,000 take-home naloxone kits,**
    - **Implementing 20 overdose prevention sites in the hardest-hit areas of the province,**
    - **Working to increase the number of supervised consumption services and**
    - **Providing added resources to BC Emergency Health Services.**
- **We are also taking action to provide better supports for long-term treatment and recovery, including:**

    - **Opening 60 additional substance use treatment beds and 50 outpatient treatment spaces. This is in addition to the promised 500 new substance use treatment beds – with almost 400 open to date and the remainder to be open by March 31st and**
    - **Expanding access to opioid substitution therapies like buprenorphine/naloxone and supporting the work of the BC Centre on Substance Use.**
- **As of February 1, 2017, PharmaCare is now providing 100% no-cost coverage for buprenorphine/naloxone and methadone to lower-income British Columbians.**
- **Health authorities have also been working to expand access to these opioid substitution treatments and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing these treatments.**
- **In addition, the College of Registered Nurses of BC is working to expand scope of practice for nurse practitioners providing addictions care to include the provision of buprenorphine/naloxone and methadone treatment.**

If asked about prescription heroin:

- **B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as buprenorphine/naloxone and methadone – treatments that work well for the majority of patients.**
- **More work needs to be done to gain a better understanding of how the evidence supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.**
- **However, B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone as treatments for opioid use disorder. These treatments are provided to former participants in clinical trials on diacetylmorphine and hydromorphone as treatments for opioid use disorder.**
- **We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.**
- **The experience with injectable hydromorphone treatment through the Providence/VCH-operated Crosstown Clinic is supporting this work. The BC Centre on Substance Use and the Provincial Health Officer are also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatments – might play in our overall response.**
- **The Ministry of Health is reviewing any recommendations with health authorities and other stakeholders to prepare options for consideration.**

Communications Contact:	Sarah Newton	Reviewer:
Program Area Contact:		
File Created:	March 2, 2017	
File Updated:	March 24, 2017	

ADVICE TO MINISTER

Minister's Office	Program Area	Deputy	HLTH Communications
	BE, BH, PK	AP	SP

ADVICE TO MINISTER

CONFIDENTIAL ISSUES NOTE **Ministry: Health** **Date: Dec. 22, 2016** **Minister Responsible: Terry Lake**	**Overdose Response: Suboxone and Alternative Treatment Options**

BACKGROUND REGARDING THE ISSUE:

- In April 2016, results of the ground-breaking Study to Access Longer-term Opioid Medication Effectiveness (SALOME) research showed that chronic heroin addiction has another effective treatment tool in hydromorphone (a licenced pain medication).
    - The study was led by researchers from Providence Health Care, the Centre for Health Evaluation and Outcome Sciences at St. Paul's Hospital, and the School of Population and Public Health at the University of British Columbia.
- While methadone and suboxone are effective for many people with opioid addictions, there is a proportion of people who have not found success with those treatments. That is why alternative treatments, like hydromorophone, may be able to assist.
- Pharmacists receive $17 per visit when prescribing methadone at a pharmacy; prescriptions for Suboxone do not generate any revenue for the pharmacists, so it is expected there could be a financial disincentive to providing Suboxone.

ADVICE AND RECOMMENDED RESPONSE:

- **The overdose crisis is a complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm reduction, and addiction and recovery treatment, as well as legislation that crosses many jurisdictional boundaries.**
- **The first line of treatment should be offering acceptable opioid replacement therapy: that is suboxone or methadone.**
    - **We are encouraging Health Authorities to look at these treatment methods.**
- **Methadone is currently being provided to 16,000 British Columbians.**
- **Suboxone is, for us in Canada, is a newer and safer drug.**
    - **It combines an opioid agonist, which means it works like an opioid with an antagonist, which means it'll block a potential overdose.**
- **Rapid detoxification or withdrawal, although it may work for some people, carries a very high risk of relapse and increase death risk from an overdose when a person has lost their tolerance.**
- **There is no quick and easy solution to the overdose crisis. However, we are mobilizing across all sectors to do all we can to respond and save lives.**

If asked about alternative or trial treatments (e.g. hydromorphone) and accessibility:

- **There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and suboxone.**

- **For example, the Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for approximately 150 patients, providing optimized medication assistance treatment program that is targeted toward patients who have not found other opiate addiction treatments to be helpful.**
- **We are focused on providing opioid substitution therapies such as methadone and suboxone and improving access to these.**
    - **We worked with the College of Physicians & Surgeons to delink suboxone from needing a methadone maintenance treatment license so suboxone is more available and more accessible.**
- **We're funding the BC Centre for Substance Use under Doctor Evan Wood to provide training and backup and support for the front line individuals.**
- **And we recently, we provided $5 million in supports for the Joint Task Force on Overdose Response as part of an investment of over $43 million earmarked for the opioid crisis.**
- **We will continue to examine research on alternative therapies.**

Communications Contact: Reviewer:
Program Area Contact:
File Created: Dec. 22, 2016
File Updated:

Minister's Office	Program Area	Deputy	HLTH Communications

Vancouver CoastalHealth

CONFIDENTIAL ISSUES NOTE

June 8, 2016

Supervised Injection Services expansion planned

Based on the lifesaving success of Insite and peer reviewed research demonstrating the benefits supervised injection services. VCH Vancouver Community, Public Health and Providence Health Care are looking at expanding supervised injection services in Vancouver. This is one strategy of a broader response to the Public Health Emergency called because of opiate overdose deaths.

Background

- As part of the provincial public health emergency response, VCH and Providence Health Care have developed a response plan that encompasses prevention harm reduction and addiction treatment strategies. Expansion of supervised injection services are one aspect of this comprehensive response.
- VCH and Providence Health Care are considering five potential sites in which supervised injection services (SIS) will be embedded within existing acute and community health care already being provided.
- SIS is being considered at the Community Care Transition Team (CTCT), Living Room Mental Health and Substance Use Drop-in, two community health care centres (CHC) in Vancouver, and St. Paul's Hospital, 10C.
- The model being pursued is similar to that at the Dr. Peter Centre, in which supervised injection services are integrated into an existing program and accessible to the clients and patients of that program.
- This expansion has been was identified in our Second Generation Strategy in the Downtown Eastside.
- While the specific locations remain confidential, the acute care hospital is St. Paul's and the CHCs being looked at are Raven Song, Heatley/Strathcona, Robert & Lily Lee Centre, or Three Bridges. These locations are in non-residential areas and close to the target audience.
- This is the first part of the extensive application process to Health Canada for an exemption to operate as outlined by the Respect for Community Act. The process requires consultation with stakeholders and is expected to take several months. It does not require public forums or town halls, only a demonstration that key stakeholders have been consulted and identified issues have been addressed.
- VCH hopes to have the applications completed by the end of 2016.
- Dr. Patricia Daly is expected to meet with Vancouver City Council June 15 to discuss VCH's intent to move forward with applications and request support.
- Engagement with the Vancouver Police Department leadership has begun and the initial plans have been well received.
- Through exemptions from Health Canada, VCH and Providence Health Care currently provide supervised injection services at three sites: Insite, the Dr. Peter Centre (DPC) and at the Crosstown Clinic.
- The Dr Peter Centre has been offering supervised injection services, incorporated into their programming, for more than 16 years. Insite has been providing service for 13 years.
- The Crosstown Clinic supervises injection of prescription dicetyl morphine and hydromorphone as an evidence-based addiction treatment service.
- Supervised injection services include: assessing and monitoring for signs and symptoms of drug overdose or toxicity; counselling and teaching safer injection practices and techniques, referring clients to other health care services including drug and alcohol counselling and detox; assessing for signs and symptoms of soft tissue injury, providing required basic wound care and making referrals for further treatment; and administering emergency procedures, if necessary.

- Insite, Crosstown and DPC have support from the Government of B.C., City of Vancouver and numerous community organizations.
- Supervised injection can also facilitate making referrals to health and social services, including counselling and addiction treatment. In fact, supervised injection helps to build a more open, trusting relationship between the nurse and client that can actually increase the chances participants will take advantage of such services.

Key Messages

- Vancouver Coastal Health and Providence Health Care are working on preliminary plans to prevent overdose fatalities by adding supervised injection to other harm reduction services in facilities already providing care to injection drug users where staff are already exchanging needles and have expressed concern about unwitnessed overdoses.
- We are currently exploring possible locations. Once we reach that stage, as part of the Health Canada application process, we will be engaging in community consultation. We must then wait for Health Canada to assess and approve our applications.
- Access to supervised injection is especially critical given the steadily increasing rates of opioid overdoses and the presence of fentanyl in the illicit drug market in Vancouver and throughout B.C. Overdose deaths in Vancouver are on the rise and supervised injection services, like those provided at the Dr. Peter Centre and Insite, are needed now more than ever.
- Research has shown that supervised injections save lives and reduce the harms of drug use for people who are actively addicted to injectable drugs.
- Incorporating supervised injection into care of clients addicted to illicit drugs helps prevent infections, overdose deaths and the spread of disease such as hepatitis C, while at the same time engaging vulnerable people in effective HIV treatment.
- Supervised injection is just one component of a comprehensive response to the provincial public health emergency that includes prevention, awareness; harm reduction and addiction treatment strategies.

Contact information			
Contact	**Name**	**Title**	**Phone**
Program	Chris Buchner	Regional Director of Prevention	604-675-3933
	Scott Harrison	Director, Urban Health & HIV	64-806-8693
Communications	Tiffany Akins	Communications leader	604-708-5281
Patient involved	N/A		
Creation & revision history			
June 8, 2016		Briefing note created	

Key Messages – Access to prescription heroin
March 27, 2017

- There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and buprenorphine/naloxone e.g. Suboxone.
- The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for up to 150 patients, providing injectable opioids i.e. diacetylmorphine and hydromorphone, in specialized clinics under supervision.
- As part of the work of the Joint Task Force on Overdose Response, there have been discussions between the ministry, Vancouver Coastal Health, Providence Health Care and the BC Centre on Substance Use on the potential for expanding the range of available opioid addiction treatments, as part of our overall provincial approach for opioid substitution therapy, particularly in the context of the public health emergency.
- No decisions have been made at this time.
- The task force is currently examining what additional resources will have the greatest impact on saving lives, to determine next steps in the provincial response to the overdose crisis.
- The BC Centre on Substance Use is working with addictions experts across the province on research, education and training and treatment guidelines to make sure substance use

treatment for British Columbians is effective and evidence-based.

- The new opioid use disorder guideline developed by addictions experts through the BC Centre on Substance Use provides an evidence-based approach to guide doctors and nurse practitioners in treating patients suffering from opioid addiction.
- We are also expanding access to first-line opioid substitution therapies such as methadone and Suboxone and improving access to these.
- In January of this year, we announced that the Province will provide 100% coverage for opioid substitution therapies to eligible British Columbians as of February 1, 2017. Individuals who qualify for MSP premium assistance would be considered eligible for no-cost Suboxone or methadone.
- Health authorities have also been working to expand access to opioid substitution treatment in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.
- Since Oct. 1, 2016, the BCCSU has hosted 17 training sessions throughout the province with more than 1000 health-care providers at 14 locations on how best to treat patients who struggle with opioid use disorder – in particular how to safely and appropriately prescribe buprenorphine/naloxone.

Key Messages – City of Vancouver – Overdose Deaths

March 22, 2017

On March 21, 2017, the City of Vancouver put out a news release suggesting that the number of overdose deaths in March would be higher than February. The release also called on the Province to provide treatment on demand, as well as access to injectable opioid assisted therapy.

- The province has mobilized a significant response across the health system to respond to the overdose public health emergency.
- These documents are a small window into the depth, breadth and complexity of this work.
- Through ongoing efforts of staff from the ministry, health authorities, community partners, health care providers and emergency responders, we have introduced a significant number of new resources and other measures to help save lives, including overdose prevention sites, the mobile medical unit, significant expansion in access to naloxone and Suboxone, additional paramedic resources, overdose prevention outreach teams and new addictions treatment beds.
- The task force and ministry are currently examining what additional resources will have the greatest impact on saving lives, to determine how new funding from the province and the federal government can be best allocated over the coming weeks.

If asked re: expanding Crosstown or access to prescription heroin:

- As part of the work of the Joint Task Force on Overdose Response, there have been discussions between the ministry,

Vancouver Coastal Health, Providence Health Care and the BC Centre on Substance Use on the potential for expanding the range of available opioid addiction treatments, as part of our overall provincial approach for opioid substitution therapy, particularly in the context of the public health emergency.

- No decisions have been made at this time.
- The task force is currently examining what additional resources will have the greatest impact on saving lives, to determine next steps in the provincial response to the overdose crisis.

If asked re: email exchanges between Island Health, BCCDC and PHO on overdose prevention sites:

- This email exchange appears to have been an misunderstanding, which was cleared up in subsequent conversations.

Key Messages –National Day of Action on the Overdose Crisis

February 21, 2017

On Feb. 21 2017, a national day of action will be held across Canada to demand concrete actions to "end the war on drugs, remove barriers to health care and implement policies that are informed by real life experiences of people who use drugs and providers." Actions have been confirmed in 7 cities including Victoria, Nanaimo, Vancouver, Edmonton, Ottawa, Montreal and Toronto.

- We are witnessing the devastating effects the opioid overdose crisis has on families across Canada – and British Columbia in particular.
- There were 914 drug overdose fatalities in B.C. in 2016, an increase of over 79% over the number of deaths in 2015.
- We are taking this crisis very seriously.
- The perspectives of people with lived experience of substance use are essential to informing our response to this crisis, which is why the Joint Task Force on Overdose Response established an advisory committee to ensure this perspective is integrated into decision-making.
- B.C. is also taking wide-ranging action with partners across the health and public safety sectors to prevent as many future tragedies as we can.
- This includes short-term harm-reduction actions and longer-term addiction treatment and recovery pathways.
- Short-term actions and emergency response measures include making lifesaving take-home naloxone kits available throughout B.C., expanding overdose prevention sites and supervised consumption services, increasing substance use treatment beds, and improving access to Suboxone.

- While we view this crisis as primarily a health issue, it is multifaceted and requires action on many fronts.
- To this end, law enforcement is working at all levels of government to intercept and block the supply of toxic drugs.
- The Government of Canada is also taking the overdose crisis seriously – it has committed $65 million over five years as part of a national response, as well as $10 million in urgent supports for B.C. in recognition of the acute impact of the crisis here.

If asked about provincial funding:

- Provincial funding earmarked for measures supporting the overdose crisis response is approaching $100 million since the public health emergency was announced in April 2016:
    - In September 2016, Premier Christy Clark announced $10 million in funding, including $5 million to establish the new BC Centre on Substance Use and $5 million to fund strategies identified by the Joint Task Force on Overdose Response.
    - In November 2016, the Province announced $5 million in funding for BC Emergency Health Services (BCEHS) to provide greater support in this ongoing public health crisis.
    - In January 2017, $16 million was announced to increase addictions treatment services.
    - As part of this, over the next year, up to 240 people with opioid addiction will receive intensive residential

treatment in 60 additional new beds, including 20 for youth and 40 for adults.

- Another 200 people will have access to 50 intensive outpatient treatment spaces. As well, we are removing financial barriers for opioid addiction treatment medications.
- On Feb. 7, 2017, the Province announced $5 million in additional funding to the BC Centre on Substance Use, as well as $1.9 million in ongoing funding to support the centre's operations.
- On Feb. 17, 2017, the federal government announced $10 million in funding for urgent supports for B.C. in recognition of the acute impact of the crisis here, and the Province announced $5 million in in Budget 2017 to continue to support the work of the Joint Task Force to respond to the crisis.

- Other measures included in the tally are: operating a significant number of additional treatment beds; expanded access to Suboxone; enforcement actions under the Province's Guns and Gangs Strategy; additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.
- We are fighting to save lives from the opioid epidemic sweeping B.C., and we will continue to work with our partners across the health and safety sectors to combat this crisis.

If asked about prescription heroin or alternative treatments:

- B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment.
- We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.
- More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C.
- The experience with injectable hydromorphone treatment through the Providence/VCH-operated Crosstown Clinic is supporting this work.
- The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

Key Messages – Provincial actions to reduce overdoses and deaths
Dec. 16, 2016

- Drug-related overdoses are a serious concern across the continent – my heart goes out to anyone grieving the loss of a loved one.
- Experts from across B.C. are taking wide-ranging action to address this crisis and prevent as many future tragedies as we can.
- After provincial health officer Dr. Perry Kendall declared a public health emergency in April, 2016, Premier Christy Clark announced a Joint Task Force on Overdose Response in July to provide expert leadership and advice on actions to prevent and respond to the crisis.
- As part of the response, law enforcement is working at all levels of government to intercept and block the supply of toxic drugs, and health officials are working to address the immediate and longer-term health needs. The task force's work includes:
    - working with the federal government on a national approach to law enforcement and public safety, including enhanced border controls and regulation of pill presses;
    - expanding access to life-saving naloxone, developing proposals for supervised consumption services, and enhancing access to and opioid addiction treatment medications and services;
    - under a Ministerial Order, ensuring that BC Emergency Health Services and regional health authorities have the ability to provide overdose prevention services as necessary on an emergency basis;
    - investments in research, health professional education and clinical care guidance through the new B.C. Centre on

Substance Use to make sure addiction treatment is effective and evidence-based;

- a broad awareness campaign to alert people about how to prevent, identify and respond to overdoses; and
- ongoing work to support and treat British Columbians with substance-use issues.
    - Government remains firmly committed to providing better access to appropriate substance-use supports, through our commitment to create 500 new substance use beds. In the past two years, more than 220 new beds have been opened and we will reach this goal in 2017 as promised.

- The overdose crisis is a very complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm reduction, and addiction and recovery treatment, as well as legislation that crosses many jurisdictional boundaries.
- There is no quick and easy solution to the overdose crisis, but we are mobilizing across all sectors to do all we can to respond and save lives.
- This includes significant expenditures, totalling more than $43 million that has been earmarked so far to support this work.
- Many, many staff in the ministries of health and public safety, health authorities, first responders including paramedics, firefighters, and police, physicians, community workers, non-profit organizations and other involved agencies have also dedicated countless hours to mobilize the province's response.
- We're pleased to see the federal government moving forward on many of the actions B.C. has advocated for to help address the

overdose crisis. A national approach is needed, and the new Canada Drugs and Substances Strategy will help save people's lives.

- We know there is more work to do, and government is continuing to take advice and direction from the Joint Task Force, and will take further action as required based on that.

If asked if there are enough treatment beds and whether we should have enough treatment to be available immediately on demand:

- We recognize there is a need for a more coordinated and accessible system of care for addictions treatment.

- That's why we committed to opening 500 substance use beds and we stand by our commitment to reach that goal in 2017.

- And that's why we have invested significant funding to establish the new BC Centre on Substance use – which is doing work to ensure our addictions treatment system is effective and based on the latest research, and that health care providers are trained on the very latest addictions treatment protocols.

- We have also expanded access to opioid substitution therapy – such as Suboxone.

- The province, working with our partners in the health system, has made significant investment and expenditures to improve interventions, coordinate services and build a better system. This will take time.

- We also know that beds are not the only answer to this public health emergency – it involves the full continuum of care – from community and primary care, withdrawal management, supportive recovery, concurrent disorders program as well as residential treatment, and how the different pieces of the system interact.

- For instance, after initial treatment, health care providers need to look at next steps once patients are discharged – outpatient clinics and other primary care services need to be in place to take on these patients to support them through their recovery journey.

- That is part of the work that the BC Centre on Substance use is spearheading, working with partners across the health system.

- In addition, health authorities are doing work to improve community and primary care for people with mental health and substance use issues, which will help to create a more integrated system of care.

If asked if B.C. is on track to meet its commitment of 500 beds in 2017?

- We have committed to opening 500 substance use beds and stand by our commitment to reach that goal in 2017.

- Over 220 beds have already been opened and health authorities will continue to open more of these beds in the coming months.

    - Earlier this year Interior Health announced an additional 73 substance use treatment beds set to open by spring 2017.

    - This fall Fraser Health announced 97 additional beds and Island Health 38 new beds, all set to open by early 2017.

    - In total, community substance use beds have increased by 1,869 new beds or 214% since 2003, with 2,743 beds as of March 31, 2016.

If asked about supports in place in Vancouver specifically:

- Earlier in 2016, Vancouver Coastal Health released guidelines for opioid treatment under the guidance of Dr. Evan Wood, whose team is working to expand these to other regions of British Columbia.

- Through their Downtown Eastside Second Generation strategy, Vancouver Coastal Health is moving forward with plans for a low-barrier addiction treatment clinic.

- The clinic will provide wrap-around services for patients with the highest needs right in the Downtown Eastside, including opioid substitution treatment such as methadone and suboxone.

If asked about providing prescription-grade heroin and other drugs publicly:

- There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and suboxone.

- The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for approximately 150 patients, providing optimized medication assistance treatment program that is targeted toward patients who have not found other opiate addiction treatments to be helpful.

- We are focused on providing opioid substitution therapies such as methadone and Suboxone and improving access to these.

- Recently, we provided $5 million in supports for the Joint Task Force on Overdose Response as part of an investment of over $43 million to dealing with the opioid crisis.

- We will continue to examine research on alternative therapies.

If asked about City of Vancouver's approved 0.5% property tax increase to fight the opioid crisis:

- British Columbians need to come together to deal with a crisis of this magnitude, and that means collaboration and cooperation between local governments, the Province, and the federal government.

- The City of Vancouver recognizes the impact this crisis is having on their city, and they have made this decision so that they can continue to address this crisis.

- We all have a role and responsibility when faced with a public health crisis, and we have had great cooperation and support from local governments around the province to date.

- We are working together with partners from many sectors, agencies and levels of government to address this epidemic, because no single level of government can solve this on its own.

- People are dying – and leadership and action is required.

Providence
HEALTH CARE
How you want to be treated.

MEDIA ADVISORY

Embargoed until APRIL 6, 2016 8:00 AM PDT

Providence Health Care to announce results of study on alternative heroin-addiction treatments

Page 090

Withheld pursuant to/removed as

Copyright

Providence HEALTH CARE
How you want to be treated.

About the SALOME Clinical Study

Overview

The **SALOME** (Study to Assess Longer-term Opioid Medication Effectiveness) study tested alternative treatments for people with chronic heroin addiction who were not benefiting sufficiently from available treatments such as oral methadone. About 10% of the heroin-dependent population does not respond sufficiently to these treatments.

The study ran from late 2011 to late 2015, with the results appearing in the April 6, 2016 edition of the Journal of the American Medical Association (JAMA) Psychiatry.

SALOME involved **202** "chronic" heroin users - those with a history of at least five years of documented drug addiction. Participants had to have been using heroin frequently for at least one year before entering the study.

SALOME compared two similar medications – **diacetylmorphine** (DAM), the active ingredient of heroin, and **hydromorphone** (HDM), a legal, licensed pain medication. Both drugs, members of the opioid family, are produced in hygienic pharmaceutical laboratories. Neither is licensed for addiction treatment in Canada.

SALOME is the first study ever of hydromorphone as a treatment for chronic heroin addiction. Its purpose was to test if injectable hydromorphone is as effective as injectable diacetylmorphine in reducing illicit heroin use for chronic injection opioid users after six months of intervention.

Study Process

The two injectable medications were administered at Providence Health Care's Crosstown Clinic in Vancouver under the supervision of an interdisciplinary team of physicians, nurses, social workers and counselors.

SALOME was a double-blind study. Neither the participants nor the researchers or clinical team (other than the pharmacy) knew which treatment was being administered.

SALOME is the follow-up study to the North American Opiate Medication Initiative **(NAOMI),** North America's first-ever clinical trial of prescribed heroin.

Research Team

The Centre for Health Evaluation and Outcome Sciences (CHÉOS) at Providence Health Care headed the SALOME study.

Principal Investigators:

Dr. Eugenia Oviedo-Joekes: A leading addictions researcher, Dr. Oviedo-Joekes worked on a similar heroin prescription trial in Spain as well as Canada's NAOMI project.

Dr. Michael Krausz: Dr. Krausz was an investigator in another heroin trial in Germany, the largest such randomized clinical trial in Europe.

Other co-investigators:

Dr. Martin T. Schechter (NAOMI's principal investigator);

Drs. Aslam H. Anis, Nick Bansback, Suzanne Brissette, Julie Bruneau, and Christian Schultz, and Amin Janmohamed of the University of British Columbia, University of Montreal, and Providence Health Care.

Funding

The SALOME study received funding from the Canadian Institutes of Health Research (CIHR) and private donors through the fundraising efforts of the InnerChange Foundation and St. Paul's Foundation. Providence Health Care funded clinical care for participants during the study.

The cost of the study was $7.4 million.

Conclusion

The SALOME results indicate the need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes and show again the urgent need to provide new treatment options for the most severely heroin-dependent individuals. Between 60,000 to 90,000 Canadians suffer from heroin addiction. It costs taxpayers at least $45,000 per individual each year in terms of related medical, public health, policing, criminal justice and jail expenses, along with crimes against people and property.

The SALOME results suggest injectable hydromorphone is as effective a treatment as diacetylmorphine for long-term opioid dependence.

In jurisdictions where diacetylmorphine is currently not available for political and/or regulatory reasons or for patients where it is contraindicated or unsuccessful, hydromorphone could be offered as an alternative.

-30-

Reporter
Rob Shaw, Reporter
PRESS GALLERY
rshaw@postmedia.com
250-953-5932 c: 250-893-0841

Deadline Friday, January 20, 2017 4:00 PM

Request
Hi there, thanks for the transcript. I'm sorry I missed yesterday – s.22
s.22

I have some Qs for Perry Kendall and Minister Lake.
Are they available for phone interviews today?

Primarily, I'm looking at this document from July 2016 where a bunch of people met at the BC CDD (I believe minister Lake included) and came up with recommendations on what could be done on the overdose crisis:
http://www.bccdc.ca/resource-gallery/Documents/BCOAE-Meeting-Report.pdf

In some cases, it's taken until yesterday to act on those recommendations. The drug coverage for substitution therapies like Suboxone for example was recommended in July but Minister Lake only announced it yesterday. Why the six month delay?

There's also a recommendation to provide hydromorhone and/or basically pharmacy-grade heroin to people who don't respond to the Suboxone/methadone substitution therapy. Perry Kendall mentioned this in passing yesterday as a European model that BC needs to turn its attention to possibly trying. I'd like to ask him some more about it.

There's also reference in the doc to faster testing for fentanyl, which could then be used to help inform everyone of the quality of what's on the street. Why wasn't that done? Instead, six months later, the provincial lab appears deluged with work, and the coroner said yesterday she has to wait to provide the most recent test results. How long are test results taking, and is gov considering more resources there?

And then there's the issue of testing for carfentanil. That's not in the report. But I noticed the chief coroner in media reports in November when some of the carfentanil cases pop up say that she hoped to be able to test for it in December. Instead, she said yesterday it's now March. Why are there delays there as well?

Hoping to chat with Perry about the European stuff he mentioned, and the Minister about the CDC meeting recommendations/testing/delays, etc

Thanks,

Background

Recommendation

Not Acting Fast Enough on DOPA Recommendations - General

- I think if you look back over the 9 months an unprecedented amount of action has been taken to address this crisis from across governments. I would direct you to our factsheet on actions taken but some of the actions we have taken is:
    - In April 2016, British Columbia declared a public health emergency for the opioid crisis, the first province in Canada to do so. In July the Premier went even further and also established a Joint Task Force brining partners across the health and public safety together to provide expert advice on the province's response and announced the establishment of the new BC Centre on Substance Use
    - British Columbia has earmarked more than $64 million to measures that will help to combat the epidemic of overdoses – a reflection that we're taking this seriously.
    - We've worked extensively with the federal government on a national approach to law enforcement and public safety, including enhanced border controls and regulation of pill presses.
    - We've significantly expanded our take home naloxone program, established 23 overdose prevention sites in high risk areas across the province and are working on providing additional supervised consumption services.
    - Government also remains firmly committed to providing better access to appropriate substance-use supports, through our commitment to create 500 new substance use beds. In the past three years, more than 300 new beds have opened and we expect a further 100 new beds to open in January. We expect to reach our goal in March 2017.
    - In addition, we are providing $10 million to make 60 additional publicly-funded residential treatment beds available over the next year, which will put up to 240 people through a 90-day treatment program. Upon completion, people will have access to follow up supports in the community for up to a year, as the rate of relapse after treatment is relatively high, and people are at much higher risk of overdose once they have been off of opioids and lost their tolerance.
    - We are also putting in place 50 intensive outpatient therapy spaces for opioid addiction treatment. These beds and outpatient spaces will target those who are most vulnerable, and who are ready to seek treatment. Over the course of a year, this will see 200 people benefit from a 90-day outpatient treatment program. The intensive outpatient treatment will be a day program, which includes daily group and one-on-one care and services. Patients will have access to group counselling, therapy, medical consults, referrals, assessments and education such as life skills and relapse prevention and have access to the follow-up program for a year after completing the 90-day treatment
    - Another very good treatment option for people who are ready is what addictions specialists now recommend as "first-line treatment" – is Suboxone.

- The Province is now making this opioid substitution treatment, along with methadone, available to at no cost to people with lower incomes. While opioid substitution treatments have always been covered under the Fair PharmaCare plan and PharmaCare Plan C for those on Income Assistance, we know that the deductibles have presented a barrier to people with lower incomes and not all those in need of this support qualify for Income Assistance.
- Beginning next month on February 1st PharmaCare will also provide 100% coverage of methadone and buprenorphine with naloxone for eligible people with incomes of about $42,000 or less, under Plan G - the Psychiatric Medications Plan. Basically anyone eligible for the medication who receives assistance with their MSP premiums would receive it at no cost.

- We know there is more work to do. Government is continuing to take advice and direction from the Joint Task Force, and will continue to take further action as required

Delays in access to Suboxone

- The province began offering Suboxone and its generic equivalents as a regular benefit under Pharmacare last year (2016).
- As of July 1,2016, the college removed the requirement for doctors to have a federal methadone prescribing exemption in order to prescribe Suboxone.
- The BC Centre on Substance Use has been providing education sessions for health-care providers throughout the province to increase the number of doctors able to prescribe this important opioid addiction treatment. More than 500 providers have participated in these sessions since November 2016.
- As of February 1, 2017, the drug treatment will also be available under Plan G, the psychiatric medications plan, at no cost for people with lower incomes. People who are receiving B.C. social assistance are also eligible to receive the treatment at no-cost.

Test Strips for public drug testing

- We don't know enough about the reliability of fentanyl test strips at this point to advocate for their broad use, as they are relatively new.
- However, we are doing some work to evaluate their effectiveness, to see if they would be a helpful tool to promote more broadly to help reduce the risk of fentanyl overdoses.
- For example, Vancouver Coastal has pilot project at Insite in which clients are testing their drugs for fentanyl.

Lab resources

- The toxicology lab is experiencing added demand due to the overdose crisis and they are working with BC Coroners on strategies to deal with this increased demand, including staffing strategies to grow and sustain capacity going forward.
- With funding provided to fund strategies identified by the Task Force, the toxicology lab has also recently purchased a new testing instrument called a tandem mass

spectrometer, which will soon be operational to help improve capacity, sensitivity and specificity to confirm new opioid drugs like carfentanil.

- We expect to be able to test with this equipment within the next two months, after validation of new test procedures.
- While we have increased demand, we are working on strategies, including staffing to deal with demand. The new equipment will make testing more specific, therefore easier to confirm these drugs thereby making it easier to confirm the new drugs and in some cases saving time.

Delays in Testing for Carfentanil

- Carfentanil testing in B.C.'s provincial toxicology lab has now been approved by Health Canada, with carfentanil and other fentanyl derivatives added to the Health Canada controlled substances license held by the lab. In order to be able to do this:
    - The Provincial Toxicology Lab Health Canada controlled substances license had to be amended to facilitate test validation for opioid analogues (carfentanil etc.).
    - Once they had the amended license, they needed to procure testing standards, available only from the US, requiring special importation permits from Health Canada (1 month lead time).
    - New instrumentation method development and validation is an extensive process, requiring months of time and specific subject matter expertise to ensure robust sensitivity and specificity of testing.
- This means that within a month or two after validation of the new test procedures (which is going on now), B.C. will be able to test for new synthetic opioids in overdose victims. This testing capability will give us valuable information about the prevalence of this drug and whether it is playing a role in the overdose crisis.

Access to hydromorphine/alternative therapies

- There are some indications that for a small subset of individuals who haven't found success with methadone and Suboxone that alternative treatments may be able to help.
- The Providence Crosstown Clinic is an addictions clinic that cares for approximately 100 patients, providing injectable opioids in specialized clinics under supervision to those individuals who have not responded well to other treatment options. While evidence is clear that this treatment path can work for some people it is important to note that only around 5% of people with opioid addiction would be suitable to participate in this type of program (this might need changes but Evan has more details on that piece)
- A provincial investment of $5 million supported the creation of a new British Columbia Centre on Substance Use (BCCSU), which is focusing on addiction research, health provider education and clinical care guidance, and will position B.C. as a leader in expanding evidenced-based addiction treatment.

- The BCCSU is working with addictions experts across the province on research, education and training, and treatment guidelines to make sure substance use treatment is effective and evidence-based no matter where British Columbians access it in B.C.
- The Ministry of Health will continue to review research provided to us on alternative therapies like those offered at Crosstown Clinic to see how the findings may be applied in B.C.
- At this time we are focused on providing first line opioid substitution therapies such as methadone and Suboxone and improving access to these medications first.
- Since Nov. 1, 2016, the BC Centre on Substance Use (BCCSU) has hosted five training sessions around the province with more than 500 health-care providers on how to treat patients who are addicted to opioids with Suboxone.
- Earlier this week we announced that the Province will provide 100% coverage for opioid substitution therapies to eligible British Columbians as of Feb. 1, 2017. Individuals who qualify for MSP premium assistance would be considered eligible for no-cost Suboxone or methadone.
- Health authorities have also been working to expand access to opioid substitution treatment in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.

Reporter
Andrea Woo, Reporter
Globe and Mail (BC Bureau)
andreawoo@globeandmail.com
604-631-6602 c: 604-379-8133

Deadline Friday, February 10, 2017 4:00 PM

Request
Currently, 28 people who were receiving injectable hydromorphone as part of Crosstown's SALOME study are still on it. Dr Christy Sutherland at the Portland Hotel has started two other patients on it. Lots of docs (including Perry Kendall, Evan Wood, etc.) say this is an important tool and we need to expand this treatment option. I'm trying to figure out why we aren't, and the only answer so far seems to be just that we haven't. There aren't really any barriers. A recent coroner's inquest directed health authorities to (among other things) "expand diacetylmorphine (heroin) and hydromorphone treatment programs for chronic opioid users: http://www.theglobeandmail.com/news/british-columbia/bc-acting-on-jurys-recommendations-for-drug-addiction-treatment/article33790008/

Scott MacDonald at Crosstown said it would be pretty easy to do. Could just start with a room in an existing hospital or clinic. Said the directive would likely have to come from health authority CEOs.

Question: Any thoughts/plans/reaction re: this? (Regarding both heroin and hydromorphone treatment programs)

Background

Recommendation

More work needs to be done to gain a better understanding of how evidence supporting use of hydromorphone can be practically applied and implemented in B.C. The experience the Providence/VCH-operated Crosstown clinic is developing with an injectable hydromorphone treatment is proving invaluable. B.C.'s newly-released opioid treatment guidelines focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients. The BC Centre on Substance Use is also working to examine the role that additional treatments, such as injectable hydromorphone for those who have not responded to first-line treatment, might play in our overall response. The Ministry of Health looks forward to receiving and reviewing those recommendations.

Reporter
David Ball, Reporter
Metro News Vancouver
David.Ball@metronews.ca
604-648-3240 c: 604-653-7641

Deadline Monday, February 20, 2017 4:00 PM

Request
First is about prescription heroin, and why it is restricted to the SALOME/NAOMI trial participants when the evidence suggests it would significantly curb overdoses, and to clarify the Minister's comments about needing public support before advancing that path.
Metro would be an opportunity for him to help drive that public understanding among our 300,000 daily readers to better understand the rationale and evidence behind his approach.

Interview request

Background

Recommendation

B.C. is the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid addictions treatment. We are a leader in North America, as Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.

B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients. For a subset of individuals, alternative treatments, such as injectable diacetylmorphine and hydromorphone, may be able to help those who haven't found success with methadone and buprenorphine/naloxone. Concern has been heightened where individuals who have not responded well to currently available treatment are once again seeking treatment alternatives after experiencing an overdose.

More work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C. The experience with injectable hydromorphone treatment through the Providence/VCH-operated Crosstown Clinic is supporting this work. The BC Centre on Substance Use is also working to examine the role that additional treatments – such as injectable hydromorphone for those who have not responded to first-line treatment – might play in our overall response. The Ministry of Health looks forward to receiving and reviewing those recommendations as it works with health authorities and other stakeholders to prepare options for consideration.

Reporter

Megan Devlin, Producer
VICE Canada
MegKDevlin@Gmail.com
226-448-6567 c: 226-448-6567

Deadline Monday, February 27, 2017 2:30 PM

Request
I'm writing a piece for Vice Canada on the UBC medical students who are travelling to Victoria today to meet with MLAs to ask for action on the opioid crisis. I've attached their press release here.

Could health minister Terry Lake comment on the asks from these medical students?

Please note the request is for VICE Canada

Background

Recommendation

The opioid overdose crisis claimed more than 900 lives last year, and it has had a profound impact on communities throughout B.C. We recognize that this is a complex issue, and we are taking action by committing ongoing resources to tackle this crisis on many fronts.

This includes immediate short-term harm-reduction actions and emergency response measures, including significantly expanding access to naloxone (more than 30,000 take-home naloxone kits have been dispensed), implementing 20 overdose prevention sites in the hardest-hit areas of the province, working to increase the number of supervised consumption services (Vancouver Coastal Health, Island Health and Fraser Health have submitted applications) as well as providing added resources to BC Emergency Health Services.

We are also taking action to provide better supports for treatment and recovery, including opening 60 additional substance use treatment beds and 50 outpatient treatment spaces in addition to the promised 500 new substance use treatment beds, with almost 400 open to date and the remainder to be open by March 31st. We are expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.

To ensure an effective and informed system of care, we established the new BC Centre on Substance Use in 2016. The centre is focused on education for health care practitioners, clinical research on evidence-based substance use treatments and developing clinical treatment guidelines for a range of substance use disorders. The work of the centre will help ensure that the treatment system is effective, based on the latest evidence and serviced by health professionals who are trained on the latest protocols.

In recognition that a stronger cross-government approach is required for the mental-health services across the system of care, a number of provincial ministries and service agencies will be working closely together over the next year to better link services to meet the needs of patients and families. We're taking important steps to better coordinate mental health and substance use services and break down

barriers to help people connect to the services they need more quickly. This will be supported by the introduction of specialized mental health and substance use community care programs established by health authorities across B.C. These specialized community services will provide patients with a single point of contact for intake and assessment, and will ensure services are coordinated.

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment, and Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies. However, more work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C. B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients.

We also recognize that chronic pain is very difficult to deal with, and that's why we support programs and services to help individuals manage it. At a Pain BC summit held earlier this month, I had the opportunity to connect with experts and professionals and offer our continued support for improving management of chronic pain and exploring the possibility of a provincial pain strategy. We have also provided more than $500,000 to Pain BC and over $2 million to Self-Management BC in 2016/17 to work with patients and their families to manage chronic pain, among other conditions.

Budget 2017 committed $165 million for a range of targeted initiatives totalling $140 million over three years to support those with mental-health and substance-use challenges, and the Province has earmarked approximately $100 million for measures supporting the overdose crisis response since the public-health emergency was announced in April. This includes enforcement actions under the Province's Guns and Gangs Strategy, additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.

More information about our actions to combat this crisis can be found in our latest release: https://news.gov.bc.ca/releases/2017CFD0003-000369

News Release

Page 103

Withheld pursuant to/removed as

Copyright

Providence
HEALTH CARE
How you want to be treated.

Providence Crosstown Clinic

Injectable Opiate Assisted Therapy

Three Year Plan 2015/16-2017/18

Prepared by:
Scott Harrison, PHC Program Director HIV/Urban Health
Andrew MacFarlane, VCH Regional Director, Mental Health & Addiction Services
Dr. Scott McDonald, PHC Lead Physician Crosstown Clinic
Dr. Ronald Joe, VCH Associate Medical Director Addictions Services
Dr. Evan Wood, VCH Program Medical Director Addictions Services and
PHC Physician Program Director, Addictions Services

Final: 02June2015

TABLE OF CONTENTS

Introduction

Untreated opioid addiction is extremely costly to the health care system, and various reviews and community consultations (e.g. DTES Second Generation Strategy) have identified the need for innovation in this area. Over the past 15 years, supervised injectable Opiate Assisted Therapy (iOAT) has emerged as a potentially important intensive second-line treatment for entrenched opioid addiction where previous orthodox treatments (i.e. oral methadone, detox, Suboxone) have failed. In this context, VCH has asked Providence Heath Care to submit a three-year costed plan for post-SALOME trial clients who are receiving care at PHC's Crosstown Clinic. Specifically, PHC has been asked:

i. What is evidence-based best practice in identifying and treating entrenched opioid addiction where first line treatments have failed?

ii. What is the plan to move clients into iOAT and then through to less intensive medication regimen? What help / partnership from VCH is needed to transition clients to less intensive treatment?

iii. What is the funding need anticipated for FY 2015/16 and beyond (to three years)?

Crosstown Clinic Background

PHC has a decade of experience providing opiate-assisted addictions treatment in a research setting, through the NAOMI and SALOME clinical trials conducted at Crosstown Clinic in the DTES, and through its specialist addiction medicine consult team at PHC acute care sites. Recent research trials have now completed their clinical phase, and Crosstown has transitioned to providing ongoing clinical care for former SALOME research participants. (Refer to Appendix A for research on Opiate Assisted Therapy and post-trial clinical care considerations.)

PHC's Role in the Addictions Continuum

Both PHC and VCH recognize the need for ongoing injectable opioid treatment for a small number of patients living with chronic, refractory opioid addiction. This service should be included in a wider continuum of care for opioid addiction, with evidence-based eligibility criteria, transitional care planning and located in a facility which is fit for purpose. Moving forward, PHC and VCH agree that the plan for Crosstown's patients must be set within the context of a strategic plan for VCH's entire addicted population. The VCH plan (under development) will include a continuum of addictions care, use of Opioid Clinical Practice guidelines and will support VCH's Downtown East Side (DTES) Second Generation Strategy.

As illustrated in Appendix B, the addiction client's journey spans from prevention, to harm reduction, to treatment (low-barrier and traditional), to supportive recovery, to community support. "Low Barrier Treatment" includes facilitated access to injectable Opiate Assisted Therapy (iOAT), as well as access to low-barrier methadone/Suboxone clinics and fast-track / drop-in addictions services.

The inclusion of injectable Opiate Assisted Therapy (iOAT) in the continuum of services is supported by VCH's "Second Generation" strategy. In its Directions Paper 1[1], DTES stakeholders observe that "*an interim and achievable step towards the medicalization of opiates needs to be identified …*," and the strategy recommends that VCH "*continue to support research and work with academic and government partners to build the case for medicalized opiates in addition to opiate replacement and other addiction treatment programs*."

Due to its research and experience with the most severely addicted and treatment-resistant patients, PHC believes it would best serve VCH's population as a provider of a range of low-barrier addictions treatments (i.e., those listed in the blue, middle section of Appendix B). PHC's services would span from a recently proposed Fast-Track Addictions Clinic at St. Paul's Hospital, to injectable Opiate Assisted Therapy to be provided through Crosstown Clinic, relocated to a suitable site within the DTES.

European experience indicates that VCH will eventually need more than one iOAT clinic to serve the 8-10% of opiate-addicted clients who are refractory to conventional therapies (roughly estimated at 500-600 refractory clients in Vancouver). However, this need must be put in context with other needs and service gaps for VCH's addictions population, for example the 1200 patients (approximately) who are currently not engaged in methadone therapy. Therefore, the intention for the foreseeable future is to maintain a single iOAT Clinic within VCH (Crosstown), with a capacity of 200 patients, for the time being while other needs are being addressed.

To summarize: PHC's broad vision is that Crosstown's role should be that of researcher, innovator, leader, and provider of low-barrier addictions care within a VCH-PHC network of low-barrier addictions services. In the short-term, Crosstown should:

(a) be relocated and sized to serve 200 patients on an ongoing basis

(b) continue to provide low-barrier injectable Opiate Assisted Therapy (hydromorphone and/or diacetylmorphine) to former participants in the SALOME trial

(c) as former SALOME patients are transitioned to less intensive therapies, provide iOAT therapy to additional patients as identified through the VCH-PHC Clinical Pathway, to a maximum of 200 in total.

Patient Volumes and Attrition Rates

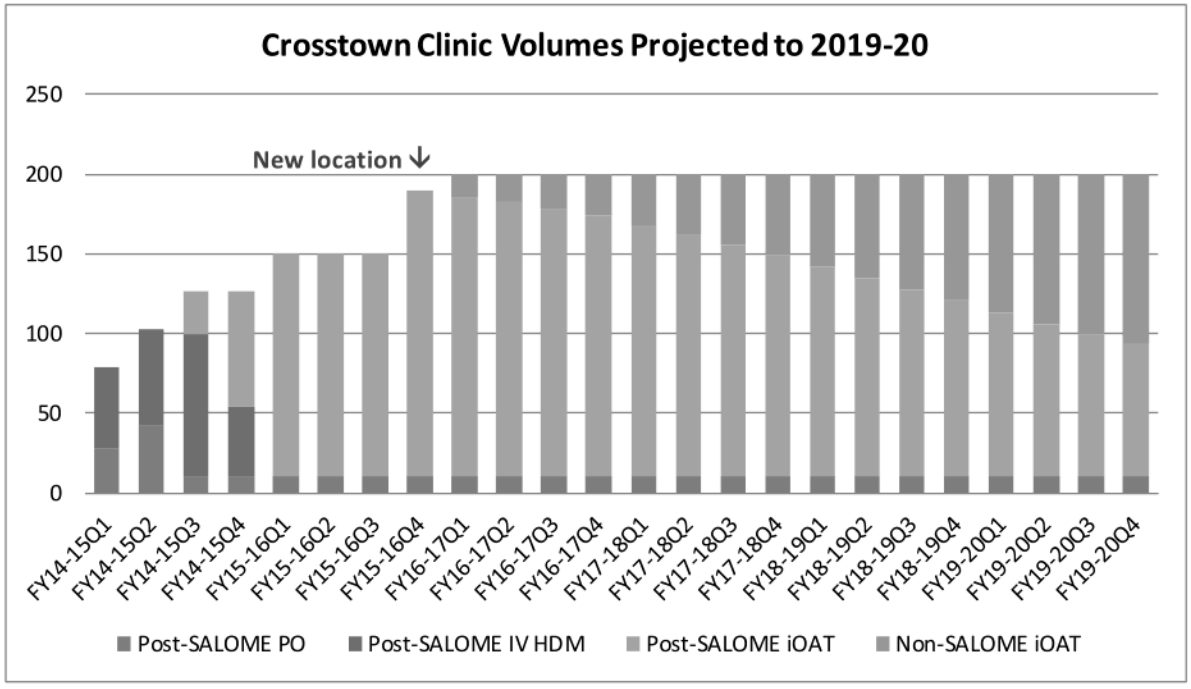
Studies in both Europe and Canada have ascertained the efficacy of supervised, medically prescribed diacetylmorphine (DAM) in specialized clinics such as Crosstown, for long term opioid users who continue to be treatment refractory despite the availability of traditional treatments like methadone. Independent systematic reviews of eight randomized trials involving a total of 2007 participants has concluded that

[1] A Second Generation Health System Strategy for Vancouver's Downtown Eastside: Directions Paper 1. Vancouver Coastal Health (2013),

treatment with DAM compared to oral methadone maintenance therapy (MMT) helps previously treatment refractory patients remain in treatment and reduce illicit opioid use [2].

In jurisdictions with longer running Supervised Injectable Heroin (SIH) programs, 6 year follow up studies demonstrated that 46% of patients still required SIH and 48% had entered other treatment programs or achieved abstinence[3]. The Swiss program demonstrated that patients remain in SIH on average for 3.7 years (median 2.8 years). Retention rates in the longer running Swiss program 50% at 2-5 years [4]. PHC's volume predictions mirror European studies, with a 50% retention rate at 5 years (100/202 - Appendix C).

As illustrated in Appendix C, Crosstown, in its current location, will reach its maximum capacity of 150 patients in Spring 2015 (Q1). The remaining SALOME participants cannot be accommodated in the current Clinic location due to space constraints. The forecasted attrition rate, coupled with a move to a new site in early 2016, will allow for the introduction of the remaining post-SALOME clients who still meet iOAT eligibility criteria (estimate 40), plus a limited number of non-SALOME patients who meet VCH-PHC iOAT eligibility criteria.



[2] Ferri, M., Davoli, M., Perucci, C.A. (2011). Heroin maintenance for chronic heroin-dependent individuals. Cochrane Database Systematic Review; 12(2011); p. CD003410 http://dx.doi.org/10.1002/14651858.CD003410.pub4

[3] Guttinger, P. Guttinger, P. Gschwend, B. Schulte, J. Rehm, A. Uchtenhagen (2003). Evaluating long-term effects of heroin-assisted treatment: The results of a 6-year follow-up. *European Addiction Research,* 9 (2),pp. 73–79

[4] Gschwend P, Rehm J, Lezzi S, et al. Development of a monitoring system for heroin assisted treatment in Switzerland. *Soz. Präventivmed*. 2002; 47: 33–8.

Clinical Operations Plan

1. Eligibility for iOAT and Clinical Treatment

Who will be served by Crosstown and the criteria for entry into injectable treatment

- During 2015/16 only former SALOME participants (n=202) are eligible for iOAT; it is currently estimated that there are 190 patients (of the 202) who currently require ongoing treatment
- PHC/VCH will provide iOAT based on rigorous assessment and based on VCH Opioid Clinical Treatment Guidelines (in production) and the 'least intensive/least intrusive' model of care, with patients moving between intensity of treatment as clinically prescribed (Appendix D)
- Patients must have ongoing illicit street heroin use (confirmed with Urine Drug Screening) and are not able to tolerate less intensive treatment (methadone/Suboxone)
- Patients who were former SALOME participants who have been stabilized onto less intensive treatment will not be titrated back to iOAT unless their current treatment is unsuccessful in reducing/stopping illicit street heroin use
- With a move to a larger site, the clinic capacity is predicted to be 200 patients at any one time within the budget and staffing model presented.
- Should vacancies in treatment slots become available, non-SALOME patients who meet the same eligibility criteria would be assessed by PHC/VCH Addiction physicians for suitability to access iOAT using a standardized and jointly agreed assessment tool
- VCH/PHC agree that some patients may require longer term iOAT to achieve stability and success

What drugs will be prescribed to iOAT patients and how this will be funded

- Current evidence from global randomized trials indicates that injectable diacetylmorphine (DAM) is the most effective treatment for chronic refractory opioid addiction
- SALOME results should be available in mid 2015, at which point VCH and PHC will determine the feasibility of injectable options based on evidence, effectiveness, safety and cost.
- Former SALOME patients who meet the criteria for ongoing iOAT have an application made to Health Canada Special Access Program (SAP) for diacetylmorphine – current approvals provide 6 months of treatment and require re-assessment for renewal
- The process for SAP approval and importation of DAM is lengthy and in the interim, patients are prescribed injectable hydromorphone until their DAM

- The Ministry of Health has provided drug cost coverage to a defined amount, as outlined under the Drug Costs section of this plan.

How clients who transition unsuccessfully into conventional care will be managed

- VCH/PHC recognize that opioid addiction is a chronic and relapsing disease
- Patients will be continually assessed to determine if they can be transitioned to less intensive treatment regimens, or to less frequent IV drug administration (2x/day vs 3x/day)
- For those who are transitioned to alternative therapy (e.g. methadone/Suboxone) and experience relapse into illicit street heroin use, transfer back on to iOAT will be supported

The measurable client outcomes required to be sustained in injectable treatment

- Decreased illicit opioid use, confirmed through random urine drug screening
- Continued evidence of engagement in injectable treatment and addiction treatment via the interdisciplinary addiction team at Crosstown
- Continued positive outcomes relating to reduce in chaotic lifestyle, stability in housing, access to employment/education with explicit measurable outcomes identified through the standard use of agreed assessment tools (WHODAS 2.0 or HoNOS)

2. Working with VCH

In order to support patients to move through the continuum of care - from chaotic use of illicit opioids to supervised opioid replacement and, for some, abstinence - a seamless service is required with as few barriers as possible. The care continuum should reflect the chronic, relapsing nature of opioid addiction, enabling patients to move between intensity of treatment as clinically indicated by their illicit substance use.

- VCH/PHC will create a Transitional Care Pathway for Opioid Addiction, based on the VCH/PHC Opioid Dependence Clinical Guidelines (currently in production). This care pathway will enable transition in both directions (iOAT ⇔ Oral)
- For patients who are ready and able to transfer to alternative treatment at any point in their trajectory, transition to full dose methadone OR Suboxone will be completed by Crosstown Clinic prior to transfer to an existing VCH or alternate HA addiction treatment program
- VCH will provide Transitional Support at the clinic to ensure patients are prepared and supported to access alternative treatment

In order to successfully transition patients from iOAT to alternate treatment methods, it is essential that low-barrier services are created. Lower threshold programs may help reduce the need for injectable options, but are also required to enable patients to be seamlessly transferred from Crosstown Clinic to VCH community addiction programs and oral substitution.

Three-Year Funding

(a) Clinic Operating Budget

The annual cost of operating the Clinic is $ 2.9 million (Appendix E). Clinic costs include the daily provision of nurses, social workers, addictions counselors, support workers and physicians, with staff on site 16 h / day 365 days/year. Clinic costs also include rent, supplies and overhead. Costs are comparable to Insite, VCH's safe Injection site, which also provides supervised injection with nursing, SW and counseling support. Although Insite serves a higher volume of patients[5], there are differences in that Insite does not dispense all doses, witness drug administration for potential diversion, offer physician-prescribed addictions management, nor provide primary care. Additionally, Insite is not bound by rigorous, federally legislated security controls and documentation requirements.

Crosstown Clinic operating costs will not change over the next 3 years, as most costs are fixed and independent of volumes (e.g., supervisor, clerk, physician sessionals, overhead). There is also little opportunity for variable savings, since the clinic must remain open 16 hours per day, regardless of whether patients are dosed 2 or 3 times daily[6]. The only possibility for reduction is if the clinic volumes fall below 100 patients daily, at which point a 12-hour day may be sufficient.

Currently, VCH contributes $1.6 m and PHC $1.3 m annually to cover clinic costs. If this funding is maintained, it will cover the projected annualized Crosstown Clinic costs for the next 3 years.

THREE-YEAR FUNDING REQUIREMENT - CLINIC Operational Costs

	2015/16	2016/17	2017/18
Clinic Cost	$2,904,399	$2,943,438	$2,933,759
Less PHC Contribution	($1,304,399)	($1,343,438)	($1,333,759)
Total Required from VCH	**$1,600,000**	**$1,600,000**	**$1,600,000**

(b) Drug Costs

Crosstown Clinic currently offers oral and IV hydromorphone and has been transitioning Special Access Program (SAP)-approved patients to IV diacetylmorphine. Assuming all SAP applications are eventually approved by Health Canada, the plan is to convert 150 IV HDM patients to DAM by June.

[5] Insite 550-650 injections / day over 18 h vs PHC 400 injections/day over 16 h (2015/16 projected)

[6] Current Crosstown average 2.5 doses per day (i.e. 50% dose twice/day + 50% dose 3 times/day).

In a Memorandum of Understanding, BC's Ministry of Health Services has committed to funding the pharmacy and drug costs for both HDM and DAM to a maximum of $2.17 million. The $2.17 m was based on 125 patients receiving oral or IV hydromorphone until the end of December 2015. There is an understanding with the Ministry that the need for ongoing drug funding will be reassessed at that point, following the release of preliminary SALOME study results in mid-2015.

At the time the MOH funding was negotiated, two assumptions were made that are no longer valid:

(a) ***Volume****:* At the time, the only treatment available was hydromorphone. In the physicians' opinion, there were approximately 125 patients likely to continue on a course of HDM post-trial, since it was anticipated many would return to street heroin. However, since the court injunction, the MDs have revised the forecast upwards. Costing is now based on the DAM volume assumptions in this plan: initial cap of 150 patients (due to space constraints), expanding to 200 with clinic relocation in early 2016.

(b) ***Price***: At the time, there was little difference between the average daily cost of a HDM or DAM patient (~$26/day). However, since then, Canada's sole supplier has increased the DAM price substantially, in part to compensate for stringent controls required by the Office of Controlled Substances. Subsequent to that, Crosstown's sub-contracted pharmacy was required to purchase the commercially available hydromorphone product rather than produce in-house, which increased the HDM cost substantially. The end result is that HDM and DAM are now roughly equivalent in cost at ~$40/day[7]. This cost is 1.5 times the original forecast of $26.

The combined result of the increased volumes and increased price is a significant funding gap. The revised forecast now shows that the Ministry's $2.17 m will be spent by September 2015. The projected shortfall for the remainder of fiscal 2015/16 is $1.23 m. With no confirmed funding source thereafter, the gap in 2016/17 and 2017/18 will be $2.8 m each year (Appendix F).

THREE-YEAR FUNDING SHORTFALL - DRUGS

	2015/16	2016/17	2017/18
Average # pts. over the year	168	200	200
Drug Costs*	$2,326,382	$2,789,257	$2,789,257
Less MOH Drug Funding	($1,094,789)	($0)	($0)
Total Shortfall	**$1,231,593**	**$2,789,257**	**$2,789,257**

** Costs for 2016/17 & 2017/18 based on 190 IV DAM + 10 oral HDM = 200 patients*

[7] Average HDM cost $42.57 / day vs average DAM cost $39.02 / day (March 2015 prices, including dispensing fees)

Summary

In conclusion:

i. Crosstown Clinic will be relocated to a 'fit for purpose' location, as close to the population served as possible (DTES or DTES adjacent).

ii. Priority patients are the 202 former SALOME participants who are clinically assessed (on an ongoing basis) as requiring iOAT.

iii. Attrition of patients may open capacity for non-SALOME patients, who are assessed by VCH/PHC Addictions physicians as being appropriate candidates for iOAT.

iv. Crosstown will continue to offer intensive case management, psychosocial, nursing and social work support and retain its model of intensive care for opioid addiction alongside the provision of iOAT.

v. Oral replacement therapy at Crosstown will be provided for the approximately 30% of iOAT patients for whom a night time methadone dose is required to avoid withdrawal.

vi. PHC/VCH will adopt joint, agreed standards for assessment, eligibility for iOAT, transitional care planning and movement through the addiction treatment continuum.

vii. VCH will support transitioning of clients by providing clinical in-reach to the clinic to assist smooth transitions to less intensive treatment for appropriate patients.

viii. Crosstown Clinic and iOAT will be incorporated into the VCH continuum of care for Opioid addiction as part of the 'low barrier' service and for the duration of the 3 year plan will be operated by Providence Health Care.

APPENDIX A: OPIATE ASSISTED THERAPY BACKGROUND

Research

NAOMI

The North American Opiate Medication Initiative (NAOMI), North America's first-ever clinical trial of prescribed heroin, took place at PHC's Crosstown Clinic from 2005 to 2008. NAOMI was a randomized trial of 251 patients (197 in Vancouver and 59 in Montréal) aimed at testing whether medically prescribed heroin (diacetylmorphine) was more effective than methadone therapy for individuals with chronic heroin addiction who were not benefiting from other conventional treatments.

The results showed that patients treated with injectable diacetylmorphine (DAM) were more likely to stay in treatment and more likely to reduce their use of illegal drugs and other illegal activities than patients treated with oral methadone.

The NAOMI study provided injectable hydromorphone (HDM), a licensed pain medication, to a small group of participants. An unexpected finding was that many participants could not tell the difference between diacetylmorphine and HDM. However, the small number receiving HDM did not permit researchers to draw any scientifically valid conclusions as to the efficacy of HDM as a treatment option.

On completion of NAOMI, researchers attempted to secure ongoing DAM treatment for participants who were benefitting, via the Health Canada Special Access Program. However, efforts were unsuccessful due to the ideological and regulatory barriers associated with DAM. This outcome is contrary to the approach of many European countries (Switzerland, Denmark, United Kingdom, Netherlands and Germany), who have provided Heroin-Assisted Therapy (HAT) legally for many years.

The NAOMI researchers speculated: "*Should HDM be proven to be as effective as diacetylmorphine, the benefits of this type of treatment may be achievable without the legal barriers and stigma associated with heroin."* Therefore, the investigators designed a study to test this hypothesis in Canada.

SALOME

The Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) was a double-blind clinical trial that tested alternative treatments for 202 people with chronic heroin addiction who were not benefitting sufficiently from current known treatments. On average, each participant had failed at traditional therapy 11 times. SALOME compared two similar medications – DAM and HDM. The study also tested if those effectively treated with these two injectable medications can be successfully switched and retained to the oral formulations of the medications. This 'Phase II' of the trial (oral phase) was halted in spring 2013, as emerging data demonstrated that oral formulations were failing to retain participants.

SALOME officially completed the clinical aspect of the trial on September 17th 2014 and the research team is now in the process of data analysis with first results likely to be published in mid-2015.

Advocacy for Opiate Assisted Therapy

After the NAOMI trial, a patient advocacy group was formed, pressing for continued access to injectable treatment for participants who had experienced success during the trial period. When SALOME was announced, NAOMI participants, community agencies and other key stakeholders formed the Community Advisory Board, which met regularly with VCH and PHC representatives during the trial period. A consistent message from the community was that those conducting the SALOME trial (CHEOS and PHC), should ensure that transition plans were in place to offer suitable alternatives to participants reaching the end of their trial. Stakeholders were adamant that patients should not be returned to a treatment which had failed them in the past, pointing out that ongoing post-trial treatment of research participants is a requirement of the World Medical Association Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects (2008, 6th Revision) (http://www.wma.net/en/30publications/10policies/b3/17c.pdf) [8] Section C. 33:

> ***"At the conclusion of the study, patients entered into the study are entitled to be informed about the outcome of the study and to share any benefits that result from it, for example, access to interventions identified as beneficial in the study or to other appropriate care or benefits'***

In partnership with VCH & CHEOS, Providence Health Care transitioned participants at the end of the trial to either injectable or oral HDM. Applications were made to the Health Canada Special Access Program (SAP) for patients who were eligible and met the criteria for ongoing DAM treatment. 21 applications were approved before the Federal Minister of Health changed the legislation in October 2013 and denied access to DAM via the Special Access Program. PHC, with the full support of the PHC and VCH Boards and the PIVOT legal society, launched a successful Supreme Court challenge with regards to accessing DAM treatment. In May 2014, an interlocutory judgment was made by the court, allowing Special Access Program applications for DAM until the full hearing takes place.

Clinical Care

Ex-SALOME participants are now classed as patients of Crosstown Clinic. Whilst the process of DAM approval is being resolved, patients are being offered continuing injectable treatment with HDM. For those with SAP, titration to DAM started in December 2014. Patients visit the clinic two to three times per day (average 2.5 times) at which, after a pre-treatment assessment (for safety reasons), they receive their medication. After injecting their medication, participants are observed until staff determines that it is safe for them to leave. Addiction Medicine doctors oversee and monitor the prescriptions.

Throughout the treatment period, an interdisciplinary team of physicians, nurses, social workers and counselors are available to help participants achieve stability in their life, seek employment and find

[8] World Medical Association (2008). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. 6th Revision. http://www.wma.net/en/30publications/10policies/b3/17c.pdf

suitable housing. Some primary care services, HIV, hepatitis C and psychiatric care are also provided by a Nurse Practitioner funded by the Ministry of Health under the "NP4BC" program.

Regulations

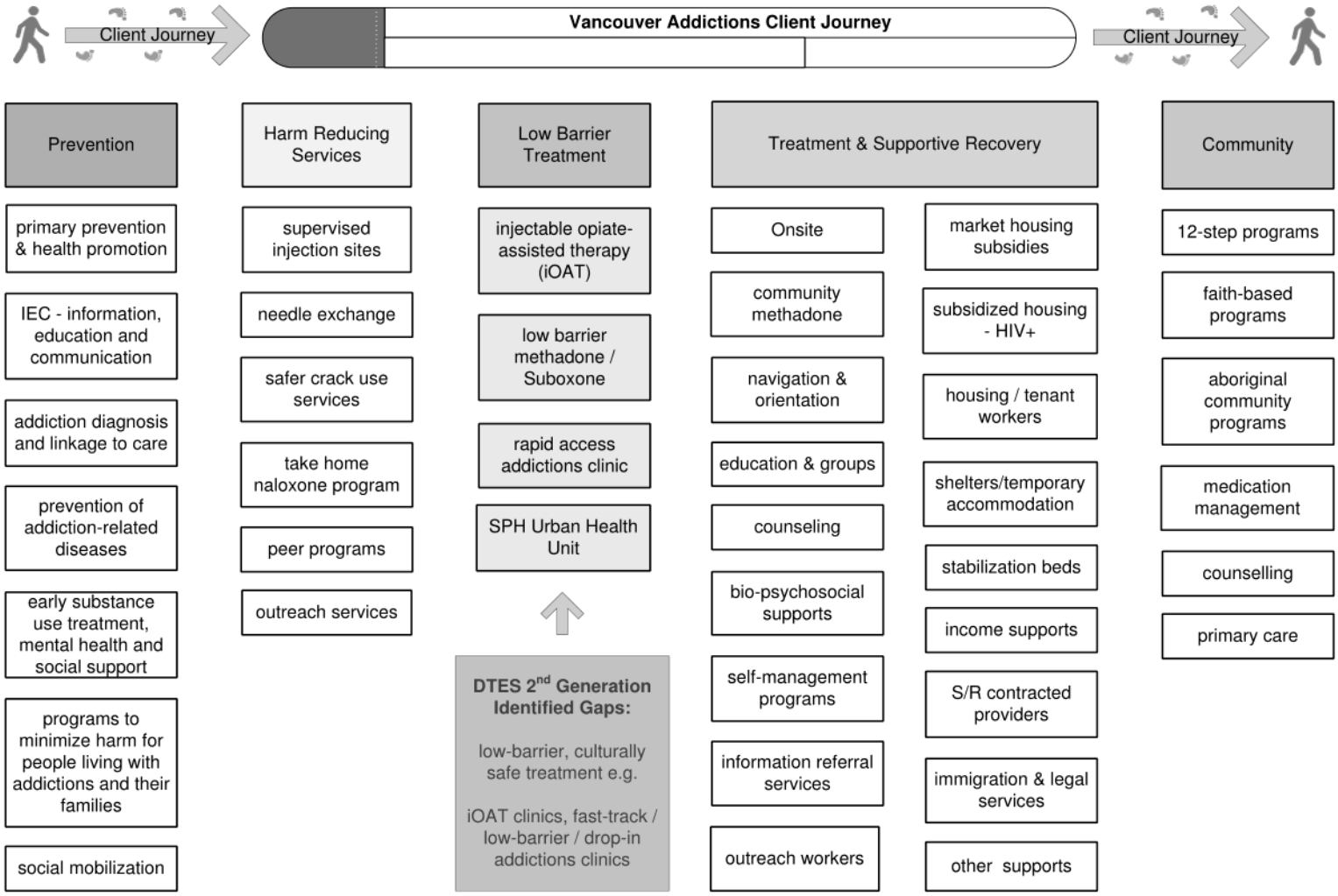
DAM remains a restricted drug under the Food and Drugs Act and is not manufactured or available for purchase in North America. The drug is manufactured in Switzerland and imported via a UK distributor to an Ontario firm, ALMAT, the major licensed dealer for narcotics in Canada. Special Access Program approval is required for each patient, with fixed volumes of DAM permitted. The drug is subsequently purchased from ALMAT by s.15,s.21 the pharmacy contracted to provide services to Crosstown Clinic. s.15, is also a Licensed Dealer for DAM importation, manufacture and distribution. It is an absolute requisite by the Office of Controlled Substances that the distributor of the DAM to the Crosstown Clinic holds a valid "Narcotic Dealer" license and complies with all Licensed Dealer legal requirements.

s.15

Patient Volumes

The clinic is currently in the process of re-engaging ex-SALOME participants in treatment. It is estimated that 95% (190) of the 202 participants will require ongoing iOAT. However, current space restrictions limit the number of IV participants to 150. PHC is therefore seeking new larger premises which are fit for purpose and sized for 200. As of mid-May 2015, there are 127 patients on diacetylmorphine, plus 23 stabilized on hydromorphone, for a total of 150 patients in treatment. Full capacity at this site (150) has been reached.

APPENDIX B: VANCOUVER ADDICTIONS CLIENT JOURNEY



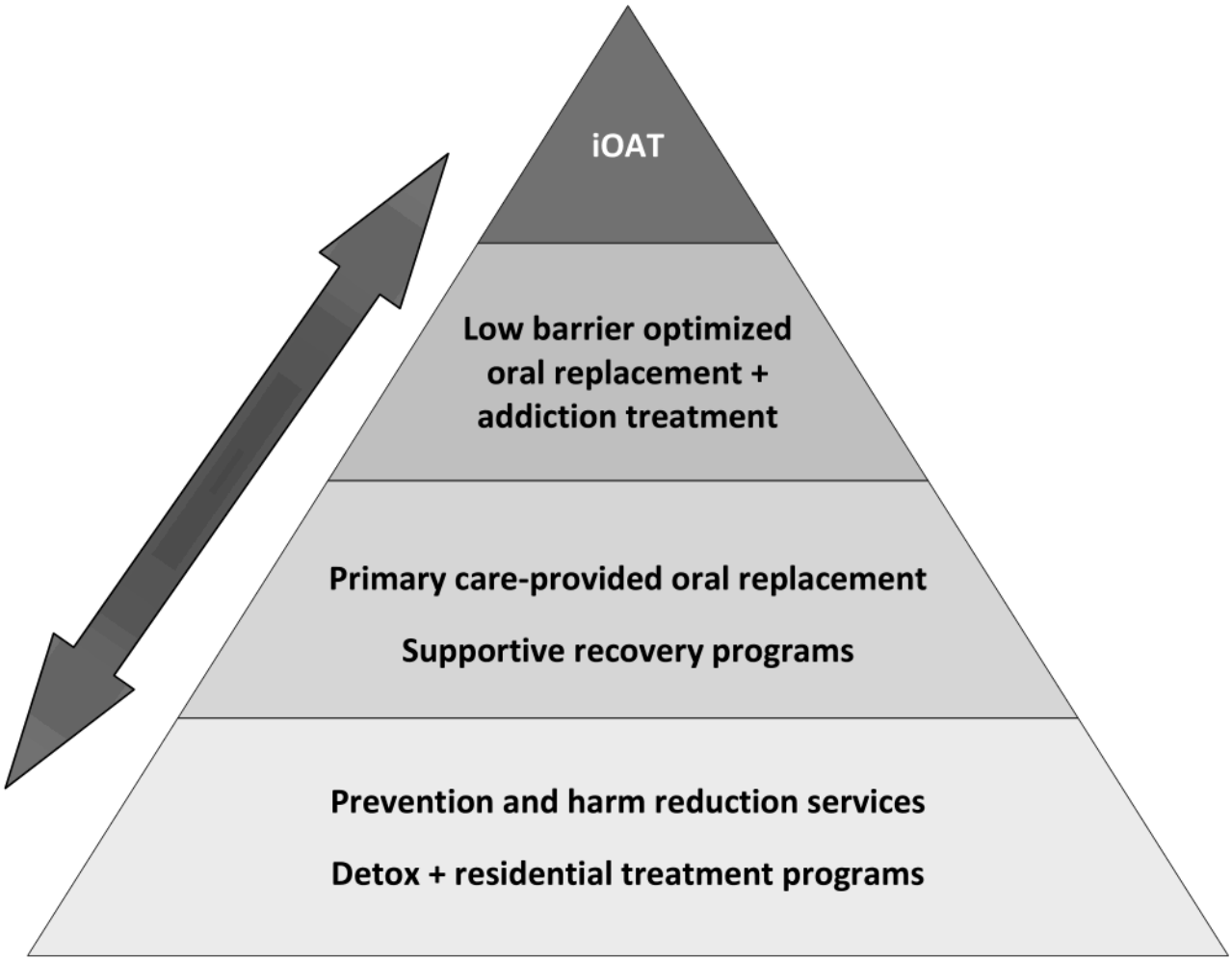
APPENDIX C: PATIENT VOLUME PROJECTIONS

		(HDM)	(HDM)	(DAM)			
Year	**Quarter:**	**Post-SALOME PO**	**Post-SALOME IV HDM**	**Post-SALOME iOAT**	**Total Post-SALOME**	**Non-SALOME iOAT**	**Notes and attrition rate %**
0	FY14-15Q1	28	51		**79**		
	FY14-15Q2	43	60		**103**		
	FY14-15Q3	10	90	26	**126**		Dec start first 26
	FY14-15Q4	10	44	72	**126**		Jan+22, Feb+24, Mar=add 46
1	FY15-16Q1	10	0	140	**150**		Apr+29, May+25, Jun+14= add 68
	FY15-16Q2	10	0	140	**150**		**cap volumes due to space**
	FY15-16Q3	10	0	140	**150**		**cap volumes due to space**
	FY15-16Q4	10	0	180	**190**		**assume new location Jan 2016; add 40**
2	FY16-17Q1	10	0	176	**186**	15	**deduct 2.5% per quarter x 1 year**
	FY16-17Q2	10	0	173	**183**	17	**add VCH patients to fill to 200**
	FY16-17Q3	10	0	169	**179**	21	
	FY16-17Q4	10	0	164	**174**	26	
3	FY17-18Q1	10	0	158	**168**	32	**deduct 4% per quarter x 1 year**
	FY17-18Q2	10	0	151	**161**	39	**add VCH patients to fill to 200**
	FY17-18Q3	10	0	145	**155**	45	
	FY17-18Q4	10	0	140	**150**	50	
4	FY18-19Q1	10	0	132	**142**	58	**deduct 5.5% per quarter x 1 year**
	FY18-19Q2	10	0	125	**135**	65	**add VCH patients to fill to 200**
	FY18-19Q3	10	0	118	**128**	72	
	FY18-19Q4	10	0	111	**121**	79	
5	FY19-20Q1	10	0	104	**114**	86	**deduct 7% per quarter x 1 year**
	FY19-20Q2	10	0	96	**106**	94	**add VCH patients to fill to 200**
	FY19-20Q3	10	0	90	**100**	100	**Post-SALOME retention 100/202 (50%)**
	FY19-20Q4	10	0	83	**93**	107	

APPENDIX D: Opioid Clinical Care Pathway

iOAT is the most intensive/intrusive treatment of chronic opioid addiction and should be reserved for those patients for whom all other optimized opioid treatments have failed. The chronic, relapsing nature of opioid addiction may require transitions to lower intensive treatment (e.g. methadone), with the ability of patients to return to iOAT if treatment fails and to retain engagement in care and treatment.

Patients can be expected and should be facilitated to move up and down the triangle of care as required, with the goal of patients succeeding in the least intensive, least intrusive setting.



APPENDIX E: CLINIC OPERATING BUDGET

Post-SALOME Hydromorphone Provision
Expense Analysis (Annualized)

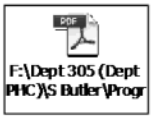
	2014-15	2015-16	2016-17	2017-18
Number of Post-SALOME clients on IV therapy (avge/year)	**86**	**158**	**190**	**190**
Average # injection visits per day (avge 2.5/patient)	**214**	**394**	**475**	**475**
Hours	**0700-1900 h (12 h)**	**0700-2300 h (16 h)**	**0700-2300 h (16 h)**	**0700-2300 h (16 h)**
Average # injection visits per hour	**17.9**	**24.6**	**29.7**	**29.7**
Clinic Salaries and Benefits Cost: *(excludes Pharmacy & Drugs)*				
Clinic Admin (DC3 + MOA)	**$ 173,932**	**$ 221,223**	**$ 221,223**	**$ 221,223**
Witnessed Ingestion (DC1 + Assist.)	**$ 1,300,830**	**$ 1,706,835**	**$ 1,706,835**	**$ 1,706,835**
Primary Care: NP4BC & 0.5 RN	**$ -**	**$ 55,692**	**$ 55,692**	**$ 55,692**
Drug/Alcohol Counseling & Case Mgmt (MSW + RN)	**$ 201,083**	**$ 255,864**	**$ 255,864**	**$ 255,864**
MD Sessionals 3/day x 250 weekdays (under review)	**$ 440,000**	**$ 376,233**	**$ 376,233**	**$ 376,233**
Med Surg & Departmental Supply	**$ 306,773**	**$ 91,373**	**$ 80,392**	**$ 70,713**
Building: Rent 64K, waste 6K, pest/bldg maintenance 12K	$ 74,801	$ 106,436	$ 156,436	$ 156,436
Contracted: housekeeping 35K, security 3K	$ 21,980	$ 37,980	$ 38,000	$ 38,000
Contracted: Paladin Security ambassador		$ 42,765	$ 42,765	$ 42,765
Contracted s.15,s.21	$ 385,000	$ -	$ -	$ -
Other: CTN Inventory/Dispensing Database		$ 10,000	$ 10,000	$ 10,000
Building (rent, waste, hskpg, security)	**$ 481,781**	**$ 197,181**	**$ 247,201**	**$ 247,201**
Total Clinic Costs (excluding Pharmacy/Drugs)	$ 2,904,399	$ 2,904,399	$ 2,943,438	$ 2,933,759

Clinic Admin:
- 1.0 DC3; 1.0
- 1.0 MOA 7.5 h M-F
- 0.50 MOA M-F (workload)

Witnessed Ingestion @ 30/h:
- Addiction Asst-Reception (1x 16Hrs/365 d)
- Addictions Asst-Inj Room/witness (1x 16Hrs/365 d)
- RN-Assessment/Intake (1 x 16Hrs/365 d)
- RN-Inj Room/witness (1x 16Hrs/365 d)
- Clinic RN/Reconciliations (2x 16hrs/365 d)

Primary Care:
- 1 x NP ($0 - NP4BC)
- 0.5 FTE RN M-F

Drug/Alcohol Counseling & Case Mgmt:
- 0.5 FTE RN M-F
- MSW Social Work (1x 7.5Hrs/M-F)
- Drug & Alcohol Councilor MSW (1x 7.5Hrs/M-F)



APPENDIX F: DRUG BUDGET

CROSSTOWN OPIATE ASSISTED THERAPY: DRUG BUDGET
FORECAST 2014/15 - 2017/18
168 PATIENTS (2015/16) --> 200 PATIENTS (2016/17-2017/18)

	MOH MOU 01Apr14-31Dec15 (21 months)	Balance of MOH budget remaining for FY 2015/16 01Apr15-31Mar16	Projected expense for full FY 2015/16 01Apr15-31Mar16	Projected funding shortfall to end of Fiscal 2015/16 (31Mar2016)	Additional Unfunded Years (Fiscal 2016/17)	Additional Unfunded Years (Fiscal 2017/18)
PO HDM @ $12.80/day	$521,422	$352,990	$46,720	$306,270	($46,720)	($46,720)
IV HDM @ $32.57/day	$850,175	$470,695	$0	$470,695	$0	$0
IV DAM@ $29.02/day		($160,677)	$1,668,287	($1,828,964)	($2,012,537)	($2,012,537)
Dispensing Fee	$798,438	$431,782	$611,375	($179,593)	($730,000)	($730,000)
	$2,170,035	**$1,094,789**	**$2,326,382**	**($1,231,593)**	**($2,789,257)**	**($2,789,257)**
Patient Mix:						
PO HDM	40		10		10	10
IV HDM	85		0		0	0
IV DAM			158		190	190
Average Pt Volume*	**125**		168		200	200
*(Q1+Q2+Q3+Q4)/4						

The MOH committed $2.17 m, which was intended to last until end of Dec-15	After 2014/15 drug expenses of $1.08 m, $1.09 m is remaining to use in 2015/16	The full FY 2015/16 will require $2.33 m, based on clinic relocation in Q3	Which leaves a $1.23 m shortfall for FY 2015/16	And a shortfall of $2.8 m for 2016/17 and 2017/18, assuming volumes are capped at 200 (exiting SALOME replaced by VCH)

QUESTIONS AND ANSWERS

Table of Contents

QUESTIONS AND ANSWERS

Overdose Prevention and Response

Updated Dec. 22, 2016

General

Q1. B.C. declared this a public health emergency in April – why hasn't government put more funding supports in place?

- In April 2016, British Columbia declared a public health emergency for the opioid crisis, the first province in Canada to do so.
- The Province also established a Joint Task Force to provide expert advice on the province's response.
- To date, British Columbia has earmarked $43 million to measures that will help to combat the epidemic of overdoses – a reflection that we're taking this seriously.
- We made our Mobile Medical Unit available and opened overdose prevention sites.
- And we continue to talk to staff who are sharing their experiences of reversing overdoses with naloxone and the opportunity these sites provide in connection people to treatment and services.
- We know there is more work to do. Government is continuing to take advice and direction from the Joint Task Force, and will take further action as required.

Q2. This has been a public emergency for almost 9 months now – why haven't overdoses come under control?

- The overdose crisis is a complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm reduction, and addiction and recovery treatment, as well as legislation that crosses many jurisdictional boundaries.
- The release of November's illicit overdose death statistics show we must continue to work together as a health and public-safety system, as a province and as a society to do everything in our power to prevent as many of these deaths as we can.
- There is no quick and easy solution to the overdose crisis. However, we are mobilizing across all sectors to do all we can to respond and save lives.

Q3. Why was the number of overdose deaths so high in November?

- We are not certain why the numbers spiked so significantly in November, but we continue to investigate that question.
- There has been speculation that carfentanil may be at play, but we don't have confirmation of that at this time.

- The BC Coroners Service's new investigation unit will be looking at each death in much closer detail, to determine if there are any commonalities or linkages that will help us to take specific action to further prevent such deaths in the future.

Q4. There was an average of 69 overdose deaths in B.C. each month this year. How does that compare to the total number of deaths?

- There are approximately 3,000 deaths per month in British Columbia every month according to Vital Stats.
- This would mean overdose deaths account for approximately two percent of all deaths.

Q5. Shouldn't the government be putting more addictions treatment resources into place because harm reduction isn't really a long-term solution?

- The overdose crisis requires both an acute response and a long-term strategy on substance use issues, involving immediate harm reduction actions combined with longer-term addiction treatment and recovery pathways.
- Substance use beds are a part of the solution but it's what happens in those beds, and, critically, it's what happens when you're discharged from a bed and the community supports that you have.
- In the past three years, health authorities have opened 300 new substance use beds and tendering processes active right now will result in more than 100 additional treatment beds opening in January.
- Government expects to meet the commitment to open 500 new substance use treatment beds by March 31, 2017.
    - Earlier this year, Interior Health announced an additional 73 substance use treatment beds set to open by spring 2017.
    - This fall, Fraser Health announced 97 additional beds and Island Health 38 new beds, all set to open by early 2017.
    - In total, community substance use beds have increased by 1,869 new beds or 214% since 2003, with 2,743 beds as of March 31, 2016.
- In addition to these beds – and in light of the current epidemic of overdoses – the Ministry of Health is looking at further expanding access to treatment for those who are ready to take steps toward recovery.
- We will be quickly bringing on additional surge capacity for treatment, with a range of different treatment beds to open early in the new year.

- But it's also important to recognize that we know beds are not the only answer to this public health emergency – the solution involves the full continuum of care – from community and primary care, withdrawal management, supportive recovery, concurrent disorders program as well as residential treatment, and how the different pieces of the system interact.
- We have invested significant funding to establish the BC Centre on Substance Use, which is working to ensure our addictions treatment system is effective and based on the latest research, and that health care providers are trained on the very latest addictions treatment protocols.
- Health authorities have also significantly expanded supports for people affected with the most severe and persistent mental illness and addictions, with 35 community-based outreach teams supporting clients across the province. These include Assertive Community Treatment and Intensive Case Management teams, 14 of which have been added in the past three years.
- The Province, working with our partners in the health system, has made and continues to make significant investment and expenditures to improve interventions, coordinate services and build a better system. This will take time.

Q6. How many new surge capacity beds is the ministry looking at, and what type of beds will they be, when and where will they open, and how much will they cost?

- The ministry is looking at a range of different bed types to quickly add more treatment capacity – residential treatment, supportive recovery and detox – with a range of different models, including harm reduction and abstinence based.
- We know that different types of treatment work for different people, so it's important to have a variety of supports to meet these varying needs.
- These beds are intended to come online quite quickly, but we are still determining the details and will have more to say about the specifics in the coming weeks.

Q7. Would more substance use beds cut down on the number of overdoses?

- Beds are not the only answer to this public health emergency – it involves the full spectrum of care – from community and primary care, withdrawal management, supportive recovery, concurrent disorders program as well as residential treatment.
- We have committed to opening 500 substance use beds and stand by our commitment to reach that goal in 2017.

Q8. Will these surge capacity beds be privately operated?

- The ministry is looking at a range of different bed types – residential treatment, supportive recovery and detox – with a range of different models, including harm reduction and abstinence based.
- These may include publicly funded beds contracted in the private sector, or health authority-operated beds.
- We are still determining the details and will have more to say about the specifics in the coming weeks.

Q9. Is it true that so many overdoses are overwhelming hospital ERs?

- Given the magnitude of the overdose epidemic, we are seeing the impact of the overdose crisis on health system, including ERs.
- At various hospitals in hotspots in B.C., we have periods of time when there is a spike of activity, reflecting what may be occurring in the community.
- We know it does affect frontline staff already supporting a busy ER environment.
- Hospitals experience ebbs and flows in demand all the time, and health authorities monitor resources and may add additional resources if required – for example St. Paul's Hospital at the epicentre of the epidemic has added additional nurses to the ER.
- We also have set up the Mobile Medical Unit and overdose prevention sites in areas with high numbers of overdoses, which we hope will also relieve pressure on emergency services.

Q10. Is it true that so many overdoses are filling up hospital ICUs?

- Because brain damage can be the result of an overdose, we have seen some cases of overdose patients in our ICUs. There were a number of cases last month at St. Paul's Hospital, but this has not created situations of overcapacity to date.

Q11. Is the overdose crisis overwhelming the province's toxicology lab and delaying testing for other patients?

- The toxicology lab is experiencing added demand due to the overdose crisis.
- To deal with the current volumes for testing, Provincial Health Services will be working on staffing strategies to grow and sustain their capacity going forward.

Q12. There have been calls for more public acceptance and public access to alternative opioid addiction treatments, such as injectable hydromorphone, which has been used in Vancouver's SALOME clinical trial. What do you make of alternative treatments like these? What are the barriers to making them more accessible?

- There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and Suboxone.
- For example, the Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for approximately 150 patients, providing optimized medication assistance treatment program that is targeted toward patients who have not found other opiate addiction treatments to be helpful.
- We are focused on providing opioid substitution therapies such as methadone and Suboxone and improving access to these.
- Recently, we provided $5 million in supports for the Joint Task Force on Overdose Response as part of an investment of over $43 million earmarked for the opioid crisis.
- We will continue to examine research on alternative therapies.

Funding

Q13. How much has been spent on the overdose crisis since the public health emergency was announced in April, 2016?

- The provincial funding earmarked for measures supporting the overdose crisis response totals more than $43 million to date since the public health emergency was announced in April.
- This includes $10 million announced by Premier Christy Clark In September 2016
    - With $5 million to establish the new BC Centre on Substance Use (BCCSU), headed by interim director Dr. Evan Wood, one of the foremost Canadian clinician researchers in addictions medicine.
        - The BCCSU was previously known as the Network for Excellence on Substance Dependence and Related Harms.
    - And $5 million to fund strategies identified under the Joint Task Force on Overdose Response.
        - Health authorities have informed the Ministry they anticipate spending $5.77 million to support the work around the public health emergency

this year – some of this is provided through the $5 million in strategies identified by the Joint Task Force.

- In November 2016, the Province announced $5 million in funding for BC Emergency Health Services (BCEHS) to provide greater support in this ongoing public health crisis. Examples of how this funding will be used include:
    - Place stationary 'medical support units' in high-overdose locations.
    - Provide more flexible modes of transportation.
        - For example, paramedics will be using bicycles and ATVs in high overdose areas to respond to medical emergencies more rapidly to move through areas that are difficult to navigate through in an ambulance.
    - Provide more supervisory support to assist paramedics and dispatchers with triaging and more efficient patient handover at busy hospital emergencies, so ambulances can get back on the road more quickly to respond to other calls.
    - Expand the Vancouver Dispatch Centre's ability to monitor and triage complex cases to further support paramedics.
    - Support paramedics in communities experiencing high overdose rates, such as Victoria and Prince George.
    - Add a BCEHS Medical Support Unit to Victoria.
    - Add more BCEHS vehicles and a stationary ambulance unit such as the Medical Support Unit anywhere it is needed.
- There are other costs that this does not incorporate:
    - Ministry funding for the Take Home Naloxone Program (funded through the BC Centre for Disease Control) - as of Dec. 19, 2016, more than 18,000 no-charge naloxone kits have been dispensed.
    - Government funding toward a public education campaign to help change the stigma around drug use and increase awareness on how to prevent, identify and respond to overdoses, plus other significant work being done within the budgets of the Ministries of Health, and Public Safety and Solicitor General.
    - In addition, the Community Action Initiative – an organization that supports projects focused on mental health and substance use issues – is using $750,000 in previous funding received from the Province through Provincial Health Services Authority (PHSA) to develop resources for parents, people who work with youth and communities.

Q14. Is this simply a case of too little, too late? You had warning this was coming in 2013.

- This crisis is a complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm reduction, and addiction and recovery treatment, as well as legislation that crosses many jurisdictional boundaries.
- The BC Centre for Disease Control formed the Drug Overdose Awareness Partnership in 2011, started sending out education messages, provided naloxone, training and harm reduction kits, developed drug awareness messaging with the RCMP and police, established the towardstheheart.com naloxone web site, and had a robust response that built up significantly between 2011 and 2015.
- It was in November 2015 that this group issued a report that was acted upon with the early 2016 public health emergency declaration.
- Perhaps in hindsight we should have done more sooner, but I would also remind all concerned that in mid-2014 until mid-2015, provincial resources were focussed on ensuring that British Columbians and all Canadians were protected against Ebloa from entering our hospitals and communities.
- There is no quick and easy solution to the overdose crisis. However, we are mobilizing across all sectors to do all we can to respond and save lives.

Q15. How is the Task Force on Overdose Response using the $5 million in funding announced by the Premier in September?

- The $5 million supports strategies identified by the task force including the issuing of intranasal naloxone and training to police and RCMP, for administering to the public in the event of overdose and for officer safety in case of accidental exposure.
- It supports additional supervised consumption services in Vancouver and locations in all health authorities, and it will help to enhance laboratory equipment at B.C.'s Provincial Toxicology Centre in the BC Centre for Disease Control to help with drug identification.
- It supported the BC Coroners Service in forming specialized drug death investigation teams, who are identifying trends and patterns to help better inform our response for community outreach on fentanyl (including community forums), and for equipment to support police with drug testing.

Q16. Will $5 million be enough for the Task Force to get what they need to stop the overdose crisis?

- This funding is supporting immediate requirements identified by the task force.

- In addition to the work of the task force, stopping the overdose crisis will require collaborative efforts by communities, health system partners and all levels of government.
- Everyone must work together if we are going to turn the tide on this deadly epidemic of overdose deaths, and all partners really are stepping up to the plate to respond.
- The funding earmarked for measures supporting the overdose crisis response in fact totals more than $43 million to date, including resources for policing, lab testing, health authorities, coroners, emergency responders, addictions treatment beds that have opened, set-up costs of supervised consumption services, naloxone, expanded access to opioid treatment medication (suboxone) and a public awareness campaign.
- The Province continues to take advice and direction from the Joint Task Force, and will take further action as required based on that.

Q17. Wouldn't the $1 million being spent on advertising be better spent on beds or other front-line responses that benefit patients or health care providers?

- Public awareness is key to addressing this crisis, and part of our multi-faceted approach.
- The campaign aims to help change the stigma around drug use and increase awareness on how to prevent, identify and respond to overdoses.
- Leslie McBain – who lost her only son Jordan to an overdose – has partnered with us to share her story in a video, as has Marilyn Oberg, a paramedic on the front lines.
- We are running public service announcements on TV and radio, and ads on social media.
- To ensure we reach a range of people, the Province has also put posters in restaurants and bars across B.C., and is partnering with many agencies across the province to put up additional posters, including in health care sites, community agencies, post-secondary schools and other appropriate venues in the communities.

Q18. Could the opioid crisis not access provincial emergency funding?

- In order for a public health emergency to be considered under the provincial *Emergency Program Act (*EPA), it would need to be declared as an epidemic – like a serious influenza or outbreak like SARS.
- The opioid crisis does not meet the criteria as it is a non-transmissible disease.

Q19. Why is the $5-million BCEHS funding announcement so important?

- Our paramedics are feeling tremendous pressure as they respond to this public health emergency on the frontlines.
- We know they have saved thousands of lives in this crisis, and we are making sure they are supported in this daunting task with needed resources.

Q20. Will the investments in the dispatch and hospital elements impact the whole province?

- It will depend on the overdose rate.
- If there's a spike, yes; however, there will not be a permanent additional resource in Kamloops as response times there are generally good.
- The resources are primarily targeted to the Downtown Eastside and Surrey, the province's two hot-spots for overdoses.
- Some resources will be directed to help support paramedics in other communities experiencing high overdose rates, such as Victoria and Prince George.
- BCEHS monitors data on 911 calls related to overdoses. If there are spikes in a particular area, this funding can assist to deploy additional resources as appropriate.

Q21. Will the investments in benefit Kamloops in anyway?

- BCEHS is continuously monitoring response times and 911 calls related to overdoses.
- At this point, the overdose calls in Kamloops have not significantly impacted response times.
- If there were a significant spike impacting Kamloops, then this funding would assist to deploy additional resources there as appropriate.
- If there were a spike, the quickest additional resource would be single responder Primary Response Units (SUVs). But they would also add ambulances as well if the spike were prolonged.

BC Centre on Substance Use (BCCSU)

Q22. How will the BC Centre on Substance Use utilize these funds?

- Under the interim leadership of Dr. Evan Wood, the BCCSU received $5 million to harness new ways to treat substance use disorders, while linking health authorities, research centres, academic institutions and service agencies to provide leadership in addiction care, research and education.

Q23. Where is the centre?

- The BCCSU will be centrally located at St. Paul's Hospital in Vancouver, but will link to health regions and communities across B.C. through a network that aims to provide expert clinical guidance and educational supports across the province.

Q24. When will it open its doors?

- The BCCSU has already established a variety of core activities, including a provincial addiction medicine education and training program for clinicians, and is developing an expert guideline for the treatment of opioid use disorder addiction.
- It will officially commence activities April 1, 2017.

Q25. How will the establishment of the BCCSU actually help address the overdose crisis?

- BCCSU will address the overdose crisis by focusing on addiction research, health provider education and clinical care guidance.
- The BCCSU will establish best practices for the province's addiction treatment system and link together health authorities, academic institutions, care providers and service agencies, to position B.C. as a leader in delivering evidenced-based addiction treatment.

Q26. How is the new BCCSU different from the work funded in part through $3 million in 2014 to set the stage for the creation of the Network for Excellence on Substance Dependence and Related Harms?

- They are the same – the Network for Excellence on Substance Dependence and Related Harms changed names to the BCCSU. The funding provided in 2014 helped set the stage for the BCCSU.

Q27. Is this funding sustainable in the long term?

- The Province's funding earmarked for measures supporting the overdose crisis response totals more than $43 million to date.
- It includes resources for policing, lab testing, health authorities, coroners' services, emergency responders, addictions treatment beds, set-up costs of supervised consumption services, naloxone, expanded access to opioid treatment medication (suboxone) and a public awareness campaign.
- The Province will explore all options for next steps as it continues to take advice and direction from the Joint Task Force, and will take further action as required based on that.

- Funding for BCCSU is also provided through private donors. s.13
s.13

- The Province, working with our partners in the health system, has made and continues to make significant investment and expenditures to improve interventions, coordinate services and build a better system. This will take time.

Task Force Funding

Q28. How is the Task Force on Overdose Response using the $5 million in funding announced by the Premier in September?

- The $5 million supports strategies identified by the task force including the issuing of intranasal naloxone and training to police and RCMP, for administering to the public in the event of overdose and for officer safety in case of accidental exposure.
- It supports additional supervised consumption services in Vancouver and locations in all health authorities, and it will help to enhance laboratory equipment at B.C.'s Provincial Toxicology Centre in the BC Centre for Disease Control to help with drug identification.
- It supported the BC Coroners Service in forming specialized drug death investigation teams, who are identifying trends and patterns to help better inform our response for community outreach on fentanyl (including community forums), and for equipment to support police with drug testing.
    - As part of this, on Nov. 1, 2016, the BC Coroners Service announced a specialized drug death investigation teams has been formed, with a goal of identifying trends and patterns that will help better inform our response.

Q29. The funding will also be used to bolster enforcement targeted at illegal fentanyl traffickers. Is this funding in addition to any other funding dedicated to the Task Force?

- The work to date by the Task Force has been carried out under existing operational funding of the agencies involved. This funding is dedicated toward priority actions identified by the task group.

Q30. Will $5 million be enough for the Task Force to get what they need to stop the overdose crisis?

- This funding is supporting immediate requirements identified by the task force.
- In addition to the work of the task force, stopping the overdose crisis will also require collaborative efforts by communities, health system partners and all levels of

government to raise awareness and reduce the stigma often experienced by people and families struggling with addiction issues.

- Everyone must work together if we are going to turn the tide on this deadly epidemic of overdose deaths.
- The province's health care system spends more than $1.4 billion per year on mental health and substance use services.

First Responders

Q31. First responders in the Province say the opioid crisis is taking its toll on them. What is being done to provide them with support?

- The overdose crisis is taking a great toll on the families and frontline workers who are directly affected.
- It's impossible to know how many lives they have saved, and we cannot thank them and the people on the frontlines throughout B.C. enough for the work they're doing.
- That is why in November 2016, the Province announced $5 million in funding for BC Emergency Health Services (BCEHS) to provide greater support in this ongoing public health crisis.
- As one of the ways to support staff, the Mobile Medical Unit (which was used during the Olympics) is now set up for the Downtown Eastside in a specific effort to take pressure off St. Paul's Hospital and paramedics.
- BC Emergency Health Services has added paramedics and resources, such as medical response units in overdose hotspots, to help relieve the pressure. The most affected hospital at the epicentre of the crisis, St. Paul's Hospital has added extra staff in their ER.
- In high-risk communities across the province, we are also working with health authorities to set up overdose prevention sites - indoor spaces where individuals trained to respond to an overdose are on-hand to help if an overdose occurs.
- Reviving and treating people who overdose can also take a significant emotional toll on health care staff and community workers. The Joint Task Force is looking at ways to better support those dealing with this on the frontlines.
- The Province is working with partners in both the health and public safety sectors to take action on many fronts to address this epidemic in the longer term as well. This includes interrupting the flow of drugs into the country, setting up supervised consumption services and improving our addictions treatment system.
- And we are also ensuring that those on the frontlines are aware of the support programs in place to help them including the Employee and Family Assistance Program

and physician health program of B.C., two 24/7 resources, along with other mental health resources in place to provide help and support.

- I thank all our front line staff across British Columbia for the work they are doing every day to save lives, and for the critical role they play in this public health emergency.

Q32. As regulations under the *Health Professions Act* and *the Emergency Health Services Act* were amended in October 2016 to enable all healthcare professionals, first responders (e.g. police, firefighters), social workers and citizens to administer naloxone outside of a hospital setting, how were people allowed to do this before?

- Previously, members of the public could administer naloxone under the *Good Samaritan Act*, and in January 2016 there was an amendment to the Emergency Medical Assistants Regulation to expand the types of first responders who could administer naloxone. However, some health professionals were restricted from administering.
- The amendment is also extended to all citizens, which allows people employed in places where overdoses are more likely to happen but where few health care workers or emergency responders are regularly employed, such as shelters and certain mental health and substance use services.

Q33. Is there a concern about first responders, coroner's staff, and medical staff dealing with PTSD from the sheer scope of this emergency?

- We are concerned about the stress on everyone who has been touched by this crisis – from first responders and health care workers, to the families of those who have overdosed.
- The Joint Task Force is looking at ways to better support those dealing with this on the frontlines.
- We are also working in discussion with Victim's Services about options for better supporting families who are affected.

Federal Response

Q34. What about the new Canadian Drugs and Substances Strategy?

- We're pleased to see the federal government moving forward on many of the actions B.C. has advocated for to help address the overdose crisis.
- A national approach is needed, and the new Canadian Drugs and Substances Strategy, once developed, will help save people's lives.

  - We want to be part of developing this as it is an important step forward.

- We welcome the federal government's changes to applications for supervised consumption sites, with only five factors to be considered as well as making renewal processes easier.
- Making it easier to establish supervised consumption services by streamlining the federal application process will not only prevent overdose fatalities, it will help connect people into care.
- A consistent, cross-Canada approach to effectively regulate and restrict access to pill presses and tableting machines is great news.
- We've consistently pushed for a national approach to ensure we effectively limit access to and illegal use of this equipment, given most of these machines are imported and easily transported between provinces.
- And we're pleased the federal government is putting a national Canadian Drugs and Substances Strategy in place, a move that is based on the pillars of prevention, treatment, enforcement and harm reduction.
- We continue to believe a strong federal response in support of our efforts will be most effective in helping to save lives and we thank the federal government for bolstering the tools in place to combat this crisis.
- And we continue to work with the federal government – in fact, in addition to meetings between the federal and provincial ministers of health, the Mayor of Vancouver and senior government officials late in 2016, staff from the Ministry of Health met with Prime Minister Justin Trudeau just before Christmas to talk about the Joint Task Force plan, the importance of a quick passage for federal Bill C-37, supports for human resources, and a Canada-wide strategy for dealing with stigma, prevention, evidence-based research, and public safety.
- Anything more the federal government can offer is welcome and appreciated.

Q35. Does the federal drugs and substances strategy go far enough?

- We are pleased that the federal government is planning to put in place so many of the measures we were calling for them to take action on.
- There is more we have asked them to do to help us respond to the overdose crisis, including establishing a national overdose surveillance system, enhancing criminal sanctions for production, importation and trafficking of illicit drugs, and adding back resources for RCMP in B.C.

- We continue our discussions with the federal government on these issues.
- Anything more the federal government can offer is welcome and appreciated.

Q36. What is being done to limit illegal drugs entering Canada from China?

- The RCMP announced an agreement with China to strengthen coordinated law enforcement actions to disrupt the supply of illegal fentanyl and synthetic opioids. Discussion to formalize the joint investigations is underway with the Canada-China Working Group meeting between the two agencies.
- While provincial and local enforcement will remain critical, this is a step forward. It is an essential step that aligns with B.C.'s advocacy with the federal government in our fight against the overdose crisis, and we welcome this swift action.
- We look forward to the same level of commitment from the federal government on a national strategy recently proposed to control access to pill presses and precursors.

Q37. What can you tell us about the federal advisory committee?

- In December 2016 in B.C., the Public Health Agency of Canada and Health Canada, the Public Health Network of Canada, and the Council of Chief Medical Officers of Health set up a strategic advisory committee to try and coordinate a pan-Canadian, national response, to this opioid crisis.
- It's a similar structure to what was set up for H1N1 and to respond to the Ebola virus. So we now have, or we will soon have, a national coordinating structure, and we'll be linking with policing and public safety as part of it.

City of Vancouver

Q38. What do you think about the City of Vancouver's approved 0.5% property tax increase to fight the opioid crisis in the city?

- British Columbians need to come together to deal with a crisis of this magnitude, and that means collaboration and cooperation between all levels of government.
- The City of Vancouver recognizes the impact this crisis is having on their city, and they have made this decision so that they can continue to address this crisis.
- We all have a role and responsibility when faced with a public health crisis, and we have had great cooperation and support from local governments to date.
- We are working together with partners from many sectors, agencies and levels of government to address this epidemic, because no single level of government can solve this on its own.

- People are dying – our citizens are counting on all of their leaders to respond and action is required.

Q39. We understand the City of Vancouver has also asked the feds for more funding to deal with a number of issues, including the opioid crisis? Is that appropriate?

- I can't really comment on that, except to say that we all have a role and responsibility when faced with a public health crisis – locally, provincially and federally.
- We are working together with partners from many sectors, agencies and levels of government to address this epidemic, because no single level of government can solve this on its own.

Supervised Consumption Services and Overdose Prevention Services

Q40. Why isn't the government providing more supervised consumption services?

- There is very clear evidence of the benefits of supervised consumption services. They reduce the risk of transmitting infectious diseases such as HIV and Hepatitis C, help prevent overdose deaths, and engage marginalized people in the health system.
- All health authorities are actively working on new supervised consumption services — with most health authorities expecting to submit at least one new site application to Health Canada before the end of the year. A key part of this process is consultations with the communities with the greatest need for these services.
- The placement of overdose sites and the resources expended on this area is still controversial in some communities.
- They will save lives and they will also bring more order to many communities where public injecting is a problem.
- What they will not do is bring problems into these communities. Communities will already be affected.
- Trained staff will monitor people at risk of an overdose and will be on hand to immediately administer naloxone when it is needed, as well as administer rescue breathing or call 9-1-1.

Q41. Why are you implementing overdose prevention services at this time, and how long will they be in operation?

- The recent dramatic spike in overdoses and the cold weather together lend a new urgency to the opioid overdose crisis in B.C.

- Despite training thousands of individuals to recognize overdoses and reverse them with naloxone, and taking many other actions across the health and public safety sectors, we have not yet been successful in stemming the death toll.
- The onset of colder weather brings increased risk of death and brain damage from a combination of overdose and hypothermia.
- Following reports to the Joint Task Force, and on the recommendation of our Provincial Health Officer, we moved forward with options for overdose prevention that do not breach the *Controlled Drugs and Substances Act* while we wait for Health Canada approval of supervised consumption sites.
- This resulted in a ministerial order on Dec. 9, 2016, which ensures that BC Emergency Health Services and regional health authorities have the ability to provide overdose prevention services as necessary on an emergency basis.
- The Minister of Health has the authority to, under section 5.2 of the *Emergency Health Services Act* and section 7.1 of the *Health Authorities Act*, take extraordinary measures in the face of a public health emergency.
- This is an emergency strategy which we will continue for as long as needed.

Q42. What's the difference between an Overdose Prevention Service and a Supervised Consumption Service?

- People who use illicit drugs are not supervised at overdose prevention sites. With supervised consumption services, people are supervised as they do illicit drugs.
- The purpose of overdose prevention services is to monitor people who have used illicit drugs for signs of an overdose, and provide rapid intervention when an overdose occurs, preventing catastrophic brain injury and death.
- Supervised consumption services have much broader goals, including the prevention of HIV and hepatitis C transmission; the prevention, detection of and early intervention for injection-related wounds and infections; instruction in safer injection practices to prevent serious and costly health problems; linkage and referral to addiction treatment and primary care; as well as overdose response.
- Overdose prevention sites are a temporary measure in response to a public health emergency, whereas supervised consumption sites are permanent fixtures.

Q43. Aren't these overdose prevention sites just illegal supervised injection sites?

- The overdose prevention sites don't break the law, as we are not supervising injections.

- Instead, they provide those who use drugs a place where they can be safely monitored and treated immediately if they overdose.
- We have had discussion with the federal government and law enforcement, and were assured that due to the nature of the sites and the ministerial order enacted earlier this month, they are not in contravention of the *Controlled Drugs and Substances Act*.

Q44. Where are the overdose prevention sites located? Who will be staffing these sites?

- 18 sites are planned for opening before the end of the month – a number of which are already open.
- This includes five sites in Vancouver, two each in Surrey, Maple Ridge, Victoria, Kamloops and Kelowna, and one each in Abbotsford and Prince George.
- These are all locations that have been experiencing significant numbers of overdoses.
- Teams of community staff who are trained in overdose response will provide people who use illicit drugs with a safe space to be monitored at these sites.
- Staff will be equipped with naloxone and appropriate training for overdose response.

Q45. Can youth access and use these sites?

- There is no age limit being contemplated for these sites. This is an emergency measure, intended to prevent overdoses in anyone who is at risk. Our goal is to save lives.

Q46. Will you still proceed with applying to Health Canada for supervised consumption services?

- Health authorities and cities continue their work toward establishing permanent supervised consumption services, which will have the supervision service integrated and embedded with other health and social services, including mental health and substance use services and referrals and peer support.
- These overdose prevention services are being opened as an emergency measure while health authorities go through the approval process.

Q47. What is the Mobile Medical Unit? Is it another Overdose Prevention Service? Who pays for it?

- The Mobile Medical Unit is a state-of-the-art medical facility that can be used in emergency situations. It is not an overdose prevention site.

- The MMU is being stationed in the Downtown Eastside to act as an alternative medical care unit for patients who overdose. It will create capacity in emergency departments such as St. Paul's Hospital, which currently sees the majority of overdose patients in Vancouver, and allow paramedics to avoid waiting at the ER, freeing them up more quickly for the next 911 call.

- Emergency physicians and nurses will be on-site to provide rapid intervention when an overdose occurs, preventing catastrophic brain injury and death, and addictions physicians will also be available to connect patients with opioid addiction treatment.
- As with any deployment of the MMU, the receiving health authority pays for all costs incurred in operating and staffing.

Q48. Why isn't the government providing more supervised consumption services?

- There is very clear evidence of the benefits of supervised consumption services. They reduce the risk of transmitting infectious diseases such as HIV and Hepatitis C, help prevent overdose deaths, and engage marginalized people in the health system.
- All health authorities are actively working on new supervised consumption services — with most health authorities expecting to submit at least one new site application to Health Canada before the end of the year. A key part of this process is consultations with the communities with the greatest need for these services.

Vancouver Coastal Health

- As part of their Downtown Eastside redesign and overall overdose crisis response, Vancouver Coastal Health is working to expand supervised consumption services where people need them most.
- B.C. has two existing supervised consumption services: Insite and the Dr. Peter Centre, both in Vancouver, and Vancouver Coastal has submitted the first two of five applications to Health Canada for additional sites.
- Vancouver Coastal Health also opened another overdose prevention service at its Mental Health and Substance Use Drop-In Centre on Powell Street

Vancouver Coastal Health Community Consultation

- Vancouver Coastal consulted with community stakeholders for the initial two sites. This included three information sessions to provide local residents, business associations, community partners and providers in Vancouver's impacted neighbourhoods with an awareness of this initiative and give them an opportunity to voice concerns.

- Three open houses were held in early October. Invitations were distributed to many different organizations. The open houses were attended by 31 community members.
- The engagement sessions are part of the extensive application process to Health Canada for an exemption to operate, as outlined by the *Controlled Drugs and Substances Act*. The process does not require public forums or town halls, only a demonstration that key stakeholders have been consulted and relevant concerns have been addressed.
- It's important to note that federal legislative changes would streamline the application process for establishing supervised consumption sites to reflect evidence that properly established, maintained and supervised consumption sites save lives. The proposed changes would replace the current 26 criteria required to establish a SCS with five factors set out by the Supreme Court of Canada.

Island Health

- Island Health plans to submit applications to Health Canada for at least two supervised consumption services by the end of 2016. Island Health is working with Victoria City Council to develop exemption requests for supervised consumption services, and they are currently seeking community feedback on proposed sites.

Interior Health

- Interior Health is exploring the option of setting up a supervised consumption services with in Kamloops and Kelowna. These are the two largest cities in the region and data shows they have had a high number of overdose deaths.
- Interior Health has had met with several stakeholders including local government, RCMP, community agencies, people who use drugs, and business associations to obtain their opinions about the feasibility of offering supervised consumption services.
- The next step is to seek input on potential locations and service models, identify any concerns and potential strategies to mitigate those concerns.

Fraser Health

- Fraser Health is looking at adding supervised consumption services in multiple communities with highest risk of overdose — including Surrey. Consultation with the City of Surrey and local RCMP is underway and community engagement sessions are planned for the near future. Their aim is to have the first round of applications in to Health Canada by the end of the year.

Northern Health

- Northern Health is working to develop a Health Canada application for supervised consumption services. Work already underway includes exploring the best way to integrate supervised consumption services with some of the other harm reduction

services already offered in downtown Prince George — including a harm reduction centre that offers a needle distribution and recovery as well as other services.

- Northern Health will be engaging the local community, downtown business and other stakeholders about these plans.

Bill C-2, Respect for Communities Act

- The evidence is clear that supervised consumption services reduce the harms from substance use and help connect people who use drugs with health care services. At Insite, currently more than 85% of drugs tested contain the potentially lethal drug fentanyl, but out of the millions of injections that have taken place, there has been not a single overdose death at the supervised consumption site.
- We are pleased the federal government is introducing legislation that replaces Bill C-2 and will streamline the application process for additional sites.

Q49. Do supervised consumption services increase demand on policing services?

- The Vancouver Police Department (VPD) has said in every letter supporting the exemption that they have no public safety concerns with Insite. Whether crime is going up or down in a particular neighbourhood can be influenced by many factors independent of a supervised injection service, and therefore it is impossible to draw conclusions based on those statistics.
- Based on police data and experience, the VPD has no such concerns regarding the Vancouver Coastal Health Authority application for additional supervised consumption services.
    - The VPD has said that Insite saves policing resources by lessening the impact to first responders, since they don't have to respond to overdoses. Police would typically respond to fatal overdoses; Insite has never had a fatal overdose.
- A study conducted one year after Insite opened showed there was no increase in crime. In fact, a decline in vehicle break-ins and vehicle theft was observed. VPD has also observed that each time Vancouver Coastal renews the Insite exemption, crime has gone down in the neighbourhood of Insite – as it has everywhere in Vancouver, so whether it would have gone down more quickly or more slowly without Insite is difficult to determine.

Naloxone

Q50. What is naloxone? How does it work?

- Naloxone is a safe medication that can temporarily reverse the effects of an overdose of an opioid drug, such as heroin, morphine, fentanyl or oxycodone.
- A naloxone kit buys time for the person suffering the overdose, until they can be further treated by a health professional after calling 911 – much like an Epi-pen for someone having an allergic reaction.
- Naloxone can be given through a needle (injection), or through a nasal spray.
- B.C.'s Take Home Naloxone Program uses the injectable form of the medication, with three doses of naloxone in the kit.

Q51. How can people get a naloxone kit?

- B.C. was the first province in Canada to establish a province-wide take-home naloxone program, which has been significantly expanded over the past few months.
- In order to receive a naloxone kit at no charge from a BCCDC approved site a person must be at risk of an overdose (i.e., people who use illegal drugs) and have successfully completed the Take Home Naloxone Program training.
- Approximately $1 million has been invested in the Take Home Naloxone program in 2016.
- Training and kits are available at more than 300 sites across B.C. and people can find a location at towardtheheart.com.
- As of Dec. 19, 2016:
    - more than 18,000 no-charge take-home naloxone kits have been dispensed – more than 13,000 of those in 2016 alone.
    - naloxone kits are now available in 367 sites across B.C. – including 57 emergency departments, and four correctional facilities.
- Given the toxicity of the opioids circulating, the Take Home Naloxone program added a third dose to their naloxone kit, because sometimes it takes more than one dose to keep a person alive.
- Currently, the nasal spray formulation is available in two dose cartons.

Q52. How can parents and friends get naloxone kits?

- People who do not use illegal drugs, including friends and family, are encouraged to complete Take Home Naloxone Program training, so they can administer the naloxone in case of an overdose.
- Naloxone kits are available at no cost to people who use illegal drugs and are at the risk of overdose. For people likely to witness and respond to an overdose, naloxone can be purchased in many pharmacies at about $50 a kit.

- Those purchasing a kit will be given instructions on how to use it and they can access online training via Towardtheheart.com.

Q53. How much does a Naloxone kit cost – is it the same price for a private citizen as the government?

s.13

Q54. Shouldn't you be making naloxone kits available to everyone?

- Our focus with public funding of naloxone is getting the kits into the hands of the people most at risk of an overdose.
- The very best thing a member of the public can do for someone having an overdose is immediately call 911.
- If the person has a naloxone kit, and you have been trained to administer it, by all means do so while you wait for emergency health services.
- If a business owner or other person wants to buy a naloxone kit and get training, we welcome that.

Q55. Why are you encouraging so many people to get naloxone kits? Isn't B.C. facing a shortage?

- There is no shortage of naloxone in B.C.

Q56. We've heard that your primary supplier is out of naloxone. Is that accurate?

s.13

Q57. Who uses the injectable form of naloxone? Why is it this form used in the Take Home Naloxone Program?

- The injectable form of naloxone is the only form used in the Take Home Naloxone program. The evidence shows the injectable form is an effective method for reversing the effects of an opioid overdose. It is also the form used by doctors, paramedics and other health professionals, and firefighters. It is also a fraction of the cost of the nasal spray version.
- Approximately $1 million has been invested in the Take Home Naloxone Program in 2016.

Q58. When will the nasal spray version be available for purchase?

- Intranasal naloxone is being distributed to RCMP detachments and some municipal police departments, following Health Canada's decision to allow emergency importation earlier this year.
- In October 2016, Health Canada approved the sale of naloxone nasal spray without a prescription and manufacturers are working to bring the product to Canada. In the meantime, injectable naloxone can be purchased in many pharmacies and pharmacies are providing training.

Q59. Who uses the nasal spray version, Narcan? Why not use it in the Take Home Naloxone kit instead?

- Health Canada allowed emergency importation of the nasal spray version of the medication in early 2016. Intranasal naloxone is being distributed to RCMP detachments and some municipal police departments, as part of the $5 million to support the work of the joint task force.
- The nasal spray version has its benefits: it is easy and quick to use. It is appropriate to help police officers accidentally exposed to opioids in their line of work. Police officers also have unique, job-related concerns about carrying needles.
- The nasal spray needs to be absorbed through the blood vessels in the nose, so it may not be as effective for some people (snorting cocaine constricts those vessels, for example; a bloody or stuffed nose would also make the spray less effective.)
- Therefore, the Take Home Naloxone Program uses the injectable version. The program has saved hundreds of lives using the highly effective injectable form.
- Nasal spray kits are also ten times more expensive than the injectable version.
- Approximately $1 million has been invested in the Take Home Naloxone Program in 2016.

Q60. Who pays for naloxone?

- The B.C. Ministry of Health and the health authorities pay for the cost of the Take Home Naloxone Program, as well as costs for naloxone use by paramedics and in emergency rooms.
- Police and fire departments fund their naloxone kits through their own agency budgets.

Q61. Why doesn't PharmaCare cover naloxone?

- Naloxone kits for people who use illegal drugs are already 100% funded by the public health care system, so the patients PharmaCare would cover already have naloxone coverage.
- Some people prescribed naloxone kits will have private insurance to cover the cost, or will be covered under the Non-Insured Health Benefits Program from Indigenous and Northern Affairs Canada. They can pick up their kits at community pharmacies.

Q62. Doesn't naloxone kill the buzz for those using it? Does that create resistance?

- Our goal is to reduce the dramatic spike in overdoses in B.C.
- We're doing anything we can to support a reduction.

Q63. How are you working with social service employees to get these kits to people?

- We have expanded the Take Home Naloxone Program to include all emergency departments, public health units, recovery homes and homeless shelters. Naloxone kits will also be made available to health practitioners at all provincial facilities where overdoses may occur.
- The Ministry of Children and Family Development is now offering no-charge naloxone kits and training to foster parents, community partners and ministry staff in Vancouver and Richmond.

Q64. Why are you not providing naloxone to schools?

- Every death is a tragedy, particularly where a young person is involved.
- Youth comprise a small number of fatal overdoses – ten youth aged 15 to 18 died of overdoses in 2016.
- Public health officials looked carefully whether to provide naloxone to schools. As no overdoses have occurred in a school, they are not designating schools a high-risk setting.
- If school administrators know they have a high-risk population in their school, or are aware of students using illegal drugs on or near school grounds, public health officials recommend buying a naloxone kit for the school from a pharmacy and ensuring a staff person knows how to use it.
- Because we know that this age group is experimenting, our public health focus for school-aged youth is on prevention through education, targeting better decision making and increasing awareness of naloxone and safer drug practices.

Q65. Is it safe for members of the public to be administering naloxone?

- Research and experience show, with basic training laypeople can recognize an overdose and administer naloxone just as well as a medical professional.
- It remains critical to call 911, even after administering naloxone to ensure the person who overdosed gets appropriate medical care. Rescue breathing is also very important.

Carfentanil

Q66. What is carfentanil?

- Carfentanil is a synthetic opioid normally used as a sedative for large animals like elephants.
- It is an analogue of fentanyl and can be 100 times more toxic than fentanyl. Fentanyl analogues are drugs with a similar, but slightly different, chemical make-up.

Q67. How much carfentanil can be fatal to a person?

- Carfentanil looks similar to table salt – on or two grains the size of table salt can be fatal to humans.

Q68. How many deaths in B.C. have been caused by carfentanil?

- One overdose fatality death has been linked to carfentanil in B.C.
- A Health Canada laboratory was able to confirm the presence of carfentanil because carfentanil was found close to the person who suffered an overdose fatality; however, the BC Coroners Service is unable to confirm whether carfentanil is the cause of death.

Q69. Will B.C. have the ability to test for carfentanil soon?

- We are pleased that carfentanil testing in toxicology labs has now been approved by Health Canada. BCCDC has had carfentanil and other fentanyl derivatives added to our Health Canada controlled substances license.
- This means that within the next two to three months we will be able to test for new synthetic opioids, after validation of these new test procedures. No additional volume of testing will be added with this change, but results will be more sensitive and specific to enable the identification of different substances.

Q70. Why can't B.C. test to see if carfentanil is what's killing people from overdoses?

- We are pleased that carfentanil testing in our provincial toxicology lab has now been approved by Health Canada.

- This means that within the next two to three months, the will be able to test for new synthetic opioids, after validation of these new test procedures.
- Even without carfentanil, illicit fentanyl alone is taking the lives of far too many British Columbians.
- *If pressed:* No additional volume of testing will be added with this change, but results will be more sensitive and specific to enable us to identify these different substances.

Q71. Can a carfentanil-related overdose be reversed with naloxone?

- The effectiveness of naloxone is in reversing a carfentanil-related overdoses is still being determined. It depends on many factors, including how much of the drug the person ingested. Carfentanil is 100 times more toxic than fentanyl so multiple hits with naloxone may be required and in some cases, naloxone may be ineffective.

Q72. Could carfentanil be the cause of November's spike in overdose fatalities?

- Carfentanil could be a factor at play. We do know that the coroner has confirmed a suspected carfentanil-related overdose death, and the police have recently seized carfentanil in B.C.
- Even without carfentanil, illicit fentanyl alone is taking the lives of far too many British Columbians.
- Clearly, illicit drugs are becoming increasingly unpredictable and increasingly perilous.
- B.C.'s Provincial Health Officer, Dr. Perry Kendall has said that it may be that there has been more toxic fentanyl than usual circulating or we may be facing the terrifying possibility of carfentanil being introduced broadly into the illicit drug stream or the arrival of another particularly lethal analogue of fentanyl.
- We'll be working our hardest in partnership with the toxicologists at the provincial toxicology centre to try to determine whether those may be driving this spike.

Fentanyl-Laced Cannabis

Q73. We are hearing that fentanyl-laced cannabis is circulating – is this true?

- There have been warnings by police to be cautious of contamination in any drug, including marijuana. In addition, there is the occasional report of overdoses where people reported taking only marijuana, but responded to naloxone.
- In such a situation, we would suspect an opioid was involved; however, we are not aware of any lab tests confirming fentanyl mixed with cannabis.

- The bottom line is that overdoses don't discriminate and anyone using any drug needs to be careful – any drug can contain fentanyl or other toxins.

Suboxone

Q74. Is suboxone an option for treatment?

- The first line of treatment should be offering acceptable opioid replacement therapy: that is Suboxone or methadone.
- Methadone is currently being provided to 16,000 British Columbians.
- Suboxone is, for us in Canada, is a newer and safer drug.
    - It combines an opioid agonist, which means it works like an opioid with an antagonist, which means it'll block a potential overdose.
- Rapid detoxification or withdrawal, although it may work for some people, carries a very high risk of relapse and increase death risk from an overdose when a person has lost their tolerance.

H1N1/Overdose response spending

Q75. Why did you spend $80 million on the H1N1 response and much less on the overdose crisis?

- It's important to note that the H1N1 pandemic and the overdose crisis are two very different public health challenges that are difficult to compare.
- In 2009/10, Cabinet approved up to $80 million in contingency funding to be made available for the H1N1 response, and just over $40 million of that was spent.
- There is a significant difference between responding to the overdose public health emergency and responding to a pandemic – which can be addressed through a relatively uncomplicated awareness, preparedness and mitigation strategy of education, rapid development and deployment of a vaccine and antiviral medications.
- It's also important to note that we are in the midst of the overdose crisis. We're still determining needs and how much funds will still need to be made available to fight this.

BC Coroners Service / Morgue

Q76. Does the BC Coroners Service have enough resources to deal with all the overdose deaths?

- Government is providing $1.1 million in funding to the BC Coroners Service (BCCS) to review all overdose deaths, as part of the funding for this public health emergency.
- This includes $450,000 to the BCCS for specialized drug investigation teams. The remaining $650,000 comes from BCCS's annual budget

Q77. What are the options for storing the deceased if the morgue is full?

- The recent increase in deaths from illicit drug overdoses has put increased pressure on the system.
- From time to time, morgues do reach capacity, especially in the winter months when hospitals experience higher mortality rates.
- In previous circumstances like this, other hospitals with space or, in some cases, funeral homes with capacity are used by the BC Coroners Service. It is working with partners both in the health care system and in funeral homes to manage these pressures.

Q78. What extra scrutiny is government putting on investigations of illicit drug deaths?

- Led by the BC Coroners Service, there is a group of 12 coroners dedicated to investigating all illicit drug deaths in B.C. using an enhanced drug overdose investigation protocol to collect consistent information on these deaths to help health authorities target meaningful interventions.
- Identifying patterns and trends among those who die will support the implementation of meaningful, long- and short-term, strategies to prevent deaths in the future.
- The compassionate and innovative approach being taken by all levels of government is heartening: from the new overdose prevention sites to a broad national acknowledgement that a health-centred approach is necessary.

Q79. Can you please give us an update on the number of overdoses so far this year?

- The updated statistics from the BC Coroners Service for November show the number of illegal drug overdose deaths has spiked – there were 128 people who died as a result of illicit drug use in November, an average of more than four per day.
    - The previous high for a single month was 82 in January 2016.
    - Individuals aged 30-49 accounted for the largest percentage of illicit drug overdose deaths from January to November at 51.7%.
    - And 80% of those who died were male.
- Since January 2016, there have been 755 unintentional illicit drug fatalities, an increase of over 70 percent over the number of deaths during the same time period last year.

  - Month-over-month, it tripled in the Fraser Health Authority, and it more than doubled for the Vancouver Coastal Health Authority. And the Vancouver Island Health Authority saw the largest year-over-year increase at over 150%.
  - The majority of these deaths occurred inside (88%).
- The latest statistics on overdose deaths are updated monthly and can be found here: http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/fentanyl-detected-overdose.pdf and http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

Supports for Youth

Q80. What are you doing to educate kids in schools about overdoses?

- Reaching kids is of vital importance. We recently launched an overdose awareness campaign to increase public awareness on how to prevent, identify and respond to overdoses.
- Under the work of the Task Force, the Community Action Initiative – an organization that supports projects focused on mental health and substance use issues – has partnered with the UVic Centre for Addictions Research of BC (CARBC) to develop several curriculum modules for teachers and resources for parents. The curriculum is available now and resources for parents will be available soon.
- The task force is also working with CARBC to develop a tool-kit to help communities – including school communities – hold forums and other public sessions to raise awareness about overdose risks due to fentanyl and other drugs.

Q81. What supports are in place for youth with substance use and mental health issues?

- The Ministry of Health invests approximately $1.4 billion every year in mental health and substance use services for all ages — which includes services provided by health authorities and physicians for youth with addictions.
- The Ministry of Children and Family Development also offers community-based, and some residential, child and youth mental health and substance use services, spending $94 million annually on these services.
- Over 27,000 children and youth receive community mental health and substance use services each year — that's more than double the number who received services in 2003.
- Families can access services, including primary care, withdrawal management and supportive recovery, youth concurrent disorders programs, and residential treatment

through their family doctor, walk-in clinics, emergent care or court appointment — and for the majority of these services, there are no waits.

- Youth who express an interest in dealing with their substance use issues are immediately connected with a variety of publicly funded substance use services ranging from day programs in the community to treatment beds.
- There are 203 beds available in B.C. for children and youth with mental health substance use challenges, but we do recognize more treatment beds are needed and we're investing in new supports.
- The Crossing at Keremeos will reopen in 2017 and will offer a 22-bed program to provide intensive residential substance use treatment for young adults aged 17-24.
- And the new 10-bed inpatient unit at the HOpe Centre will open in spring 2017 and provide specialized, intensive services for youth struggling with mental health and substance use challenges at the same time.

Legalization of Drugs

Q82. Why not just legalize drugs so they can be regulated?

- Changes regarding the legalization of currently illegal drugs are the responsibility of the federal government, as the Controlled Drugs and Substances Act (CDSA), which make some drugs illegal, is a federal statute.
- Exemptions from the CDSA to allow for the supervised use of illegal drugs can be obtained from the federal government, as has been obtained for Insite and the Dr. Peter Centre.

For GCPE Social Media Use

Ad Campaign

Q83. How much is government spending on this ad campaign?

- As of Oct. 31, 755 people in British Columbia have died in 2016 due to illicit drug overdoses. This social media campaign is one of the many actions we're taking to help prevent as many of these unnecessary deaths as we can.
- The costs are not yet finalized as this campaign is ongoing. Final costs will be provided in public accounts at the end of the fiscal year. To view pubic accounts, please visit: http://www.fin.gov.bc.ca/pubs.htm

Q84. Instead of paid Facebook posts, why don't you use that money to provide more services for people who need them?

- B.C. is taking many different actions to reduce overdoses, including a social media campaign.
- We know that through public education – including a targeted social media campaign – that we can inform British Columbians about potential harm and risk, with the potential for this information to be shared virally.

Q85. Do you honestly expect that a few Facebook ads will change anything?

- This social media campaign is the first phase in a larger campaign we have in the works. We're also working to develop resources for parents and youth and connecting with our partners on other strategies so we can reach as many people as possible.
- We know that through public education – including the use of social media– that we can inform the public about potential harm and risk.

Q86. Are there translated resources available?

- Yes, TowardtheHeart.com has their Overdose Survival Guide available in French, Simplified Chinese and Punjabi: http://towardtheheart.com/naloxone/siteresources/overdose-survival-guide

Public Information

Q87. What can people do to help prevent or respond to an overdose (for myself, a friend, a family member)?

- If someone uses drugs purchased from the illegal market occasionally or regularly, these tips can help to reduce or even prevent an overdose:
- Know your health status and your tolerance.
- Do not mix drugs and alcohol.
- Be aware: using drugs while on prescribed medications can increase overdose risk.
- Don't use alone. Leave door unlocked. Tell someone to check on you.
- Do testers to check strength. Use less. Pace yourself.
- Talk to an experienced person or a trusted healthcare provider about reducing risk.
- Carry a naloxone kit and know how to use it.

Q88. What are the signs of an overdose?

- Slow, shallow breathing or no breathing.
- Severe sleepiness or person is not moving / responsive.
- Slow heartbeat.
- Person may be choking, or you can hear gurgling sounds.
- Cold, clammy skin.
- Trouble walking or talking.
- Pupils are tiny.
- If you suspect someone may have overdosed call 911 immediately.

Q89. What do you say to those using drugs about the risk?

- We continue to stress the importance of harm reduction measures that need to be followed by anyone using an illicit drug or accompanying anyone who is using:
    - Never use alone;
    - Have naloxone and medical help readily available when using;
    - Use at an overdose prevention site or supervised consumption site wherever possible; and,
    - Learn the signs of overdose and call 9-1-1 immediately if you see those signs.

Q90. Will someone be arrested if they call 911 for an overdose situation?

- When someone calls 911 about a suspected overdose, the priority is getting the most appropriate medical care to the patient as soon as possible.

- First responders are not there to pass judgement or get anyone in trouble; they are there to help save a life.
- If someone picks up the phone and asks for an ambulance, they're going to get an ambulance. Police typically only attend overdose-related calls if there is a threat to safety or a death has occurred. They adopted this strategy so people won't be afraid of getting in trouble when they call 911 for an overdose.

$XX Funding Announcement

General

s.13

s.13

QUESTIONS AND ANSWERS

Table of Contents

QUESTIONS AND ANSWERS

Table of Contents

QUESTIONS AND ANSWERS

Overdose Prevention and Response

Updated Feb. 1, 2017

General

Q1. Can you please give us an update on the number of overdoses?

- The updated statistics from the BC Coroners Service for January 2017 show the number of illegal drug overdose deaths continuing to be extremely high – 116 people died as a result of unintentional illicit drug overdoses in January.
- This is lower than the spike in November (128) and December (142), but still very high.
- In 2016, there were 914 unintentional illicit drug overdose fatalities, an increase of over 79% over the number of deaths in 2015.

Q2. This has been a public emergency since April, 2016 – why haven't overdoses come under control?

- The overdose crisis is a complex issue involving many social factors, including housing, public safety, policing, border control, public health, harm reduction, and addiction treatment and recovery, as well as legislation that crosses many jurisdictional boundaries.
- The latest illicit overdose death statistics show that the health and public safety systems must continue to work together to do everything in our power to prevent as many of these deaths as possible.
- There is no quick and easy solution to the overdose crisis. However, all sectors across the system have been mobilized to respond to overdoses and save lives.

Q3. Why were the number of overdose deaths so high in November and December?

- It is not certain why the numbers spiked so significantly in November and December, but that question continues to be investigated.
- There has been speculation that carfentanil may be at play, but that is not confirmed at this time.
- The BC Coroners Service's new investigation unit will be looking at each death in much closer detail, to determine if there are any commonalities or linkages that will help determine what specific actions can be taken to further prevent such deaths in the future.
- In addition, once the provincial toxicology lab is able to test for carfentanil in March, we will have a better idea of how big a role carfentanil is playing in the overdose crisis.

Q4. Why are the fentanyl numbers not available with the Coroners latest update?

- Due to the high volume of cases being experienced, analysis will take additional time before the year-end figures can be provided. The Coroners Service is aiming to have those numbers available by March 2017.

Q5. Shouldn't the government be putting more addiction treatment resources into place because harm reduction isn't really a long-term solution?

- On the health sector response, the overdose crisis requires both immediate harm reduction actions and longer-term addiction treatment and recovery pathways.
- In the past three years, health authorities have opened 300 new substance use beds and government expects to meet the commitment to open 500 new substance use treatment beds by March 31, 2017.
- In addition to these beds – Government is investing more than $16 million to increase addictions treatment services. This includes additional residential treatment beds and intensive outpatient services. Over the next year, up to 240 people with will receive intensive residential addiction treatment in 60 additional new beds, including 20 for youth and 40 for adults, and another 200 people will have access to 50 intensive outpatient treatment spaces. As well we are removing financial barriers to opioid addiction treatment medication.
- But it's also important to recognize that a residential treatment bed may not be the best course of treatment for someone with opioid addiction – guidelines now recommend opioid substitution treatment (methadone and Suboxone) combined with counselling and other supports as the first step in treatment.
- We know beds are not the only answer to this public health emergency – the solution involves the full continuum of care – from community and primary care, withdrawal management, supportive recovery, concurrent disorders programming as well as residential treatment, and how the different pieces of the system interact.
- We have invested significant funding to establish the BC Centre on Substance Use, which is working to ensure our addiction treatment system is effective and based on the latest research, and that health care providers are trained on the very latest addiction treatment protocols.
- The Province, working with our partners in the health system, has made and continues to make significant investment and expenditures to improve interventions, coordinate services and build a better system. This will take time.

Funding

Q6. How much has been spent on the overdose crisis since the public health emergency was announced in April, 2016?

- Provincial funding earmarked for measures supporting the overdose crisis response is approaching $100 million since the public health emergency was announced in April.
- In September 2016, Premier Christy Clark announced $10 million in funding to provide:
    - $5 million to establish the new BC Centre on Substance Use, headed by Dr. Evan Wood, one of Canada's foremost researchers in addictions medicine.
    - $5 million to fund strategies identified by the Joint Task Force on Overdose Response.
    - A further $5 million to support the continued work of the Task Force will be included in Budget 2017.
- In November 2016, the Province announced $5 million in funding for BC Emergency Health Services (BCEHS) to provide greater support in this ongoing public health crisis.
- In January 2017, $16 million was announced to increase addictions treatment services. As part of this, over the next year, up to 240 people with opioid addiction will receive intensive residential treatment in 60 additional new beds, including 20 for youth and 40 for adults. Another 200 people will have access to 50 intensive outpatient treatment spaces. As well, we are removing financial barriers for opioid addiction treatment medications.
- On Feb. 7, 2017, the Province announced $5 million in additional funding to BCCSU, as well as $1.9 million in ongoing funding to support the centre's operations.
- Other measures included in the tally are: operating a significant number of additional treatment beds; expanded access to Suboxone; enforcement actions under the Province's Guns and Gangs Strategy; additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths; and a public awareness campaign.

Suboxone and Methadone

Q7. How many people are on opioid substitution treatment in B.C.?

- In 2016, almost 23,000 individuals in BC received Suboxone or methadone, an increase of 15% from 2015.

- In 2016, 6,800 patients in BC received Suboxone or generic buprenorphine/naloxone and 18,200 patients received methadone for opioid substation treatment. (Note: These numbers are not mutually exclusive as some patients would have switched from one treatment to another throughout the year.)
- The number of individuals receiving opioid substitution treatment has increased by 52% since 2011.

Q8. How much does PharmaCare spend on Suboxone and its generic versions per year?

- PharmaCare spent about $4 million last year on coverage for Suboxone and its generics. That is up about $1 million from the year before. We expect the expanded coverage will bring that number above $10 million next year.
- Methadone and Suboxone together accounted for almost $50 million in the PharmaCare budget last year.

Q9. What is the government doing to make this important therapy available to more people, given that guidelines from the BC Centre on Substance Use have designated it as the first-line therapy for opioid addiction treatment?

- The province began offering Suboxone and its generic equivalents as a regular benefit under PharmaCare in 2015. As of February 1, 2017, generic version of the Suboxone (and its generic equivalents) and methadone will also be available under Plan G, the psychiatric medications plan, at no cost for people with lower incomes. People who are receiving B.C. social assistance are already eligible to receive treatment at no cost.
- Health authorities have also been working to expand access to opioid substitution treatment in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.
- Since October, 2016, the BC Centre on Substance Use has hosted six training sessions around the province with more than 550 health-care providers on how to treat patients who are addicted to opioids with Suboxone.
- Improved access to this important treatment has been identified as a priority by the Task Force, and work on that front is ongoing.

Q10. Are there wait times accessing Suboxone or similar opioid substitution treatments?

- Wait times for Suboxone or methadone vary across the province depending on physician availability and capacity to prescribe and monitor. For instance, there is no wait in Kamloops, but a higher wait in Kelowna. While we don't have specific wait times

available, it is clear access to opioid substitution treatment varies, and overall it has been identified as a top priority for health authorities.

- That is why the BC Centre on Substance Use is holding training sessions around the province, to increase the number of doctors trained to prescribe this important treatment.

Alternative Treatment Options

Q11. The Provincial Health Officer seems to be calling for more public acceptance and public access to alternative opioid addiction treatments, such as injectable hydromorphone. What is the province's position on this?

- There are some indications that for a subset of individuals alternative treatments may be able to help those who haven't found success with methadone and buprenorphine/naloxone e.g. Suboxone.
- The Providence Crosstown Clinic is an addictions clinic with an interdisciplinary team that cares for up to 150 patients, providing injectable opioids i.e. diacetylmorphine and hydromorphone, in specialized clinics under supervision.
- More work needs to be done to gain a better understanding of how evidence supporting use of hydromorphone can be practically applied and implemented in B.C.
- The experience the Providence/VCH-operated Crosstown clinic is developing with an injectable hydromorphone treatment is proving invaluable.
- B.C.'s newly-released opioid treatment guidelines focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients.
- The BC Centre on Substance Use is also working to examine the role that additional treatments, such as injectable hydromorphone for those who have not responded to first-line treatment, might play in our overall response.
- The Ministry of Health looks forward to receiving and reviewing those recommendations.
- At this time, we are focused on providing first-line opioid substitution therapies such as methadone and Suboxone and improving access to these.
- In January of this year, we announced that the Province will provide 100% coverage for opioid substitution therapies to eligible British Columbians as of February 1, 2017. Individuals who qualify for MSP premium assistance would be considered eligible for no-cost Suboxone or methadone.
- Health authorities have also been working to expand access to opioid substitution treatment in response to the overdose emergency, and have increased substance use

supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.

- Since October, 2016, the BC Centre on Substance Use has hosted six training sessions around the province with more than 550 health-care providers on how to treat patients who are addicted to opioids with Suboxone.

Q12. In September 2016, Health Canada amended legislation so that any doctor can apply for the ability to prescribe pharmaceutical-grade heroin. So why hasn't B.C. expanded hydromorphone therapy beyond Crosstown?

- The amended federal legislation shows a willingness of the federal government to acknowledge that a range of treatment options need to be made available.
- Here in B.C. we support this approach, however more work needs to be done to gain a better understanding of how the evidence supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in the B.C. context.

First Responders

Q13. First responders in the Province say the opioid crisis is taking its toll on them. What is being done to provide them with support?

- Reviving and treating people who overdose is taking a significant toll on the health-care staff, community workers and families who are directly affected.
- The Minister of Health has thanked all our frontline staff across British Columbia for the work they are doing every day to save lives, and for the critical role they play in this public health emergency.
- Many frontline care providers have access to support programs such as the Employee and Family Assistance Program and Physician Health Program of B.C., two 24/7 resources, along with other mental health resources that provide help and support.
- That said, we know people on the front lines need more support.
- This is an area where the Joint Task Force is currently doing some work, in partnership with Health Emergency Management BC.
- We have engaged with workers on the front lines to determine what supports will be most helpful, and are now examining the feasibility of various options.

- Government and its partners have also taken a number of steps to increase harm reduction and emergency response services on the front lines, to help reduce the pressures and save more lives.
- Through $5 million in funding announced in November 2016, BC Emergency Health Services has added paramedics and resources, such as medical response units in overdose hotspots, to help relieve the pressure on first responders.
- The most affected hospital at the epicentre of the crisis, St. Paul's Hospital, has added extra staff in their ER. In addition, the Mobile Medical Unit is set up for the Downtown Eastside in a specific effort to take pressure off St. Paul's Hospital staff and paramedics.
- In high-risk communities throughout the province, health authorities have also set up overdose prevention sites – staffed by individuals trained to respond to an overdose.

Federal Response -

Q14. What is B.C.'s reaction to the Canadian Drugs and Substances Strategy?

- We're pleased to see the federal government moving forward on many of the actions B.C. has advocated for to help address the overdose crisis.
- A national approach is needed, and the new Canadian Drugs and Substances Strategy and corresponding amendments to the *Controlled Drugs and Substances Act* through Bill C-37, once developed, will help save people's lives.
- We welcome the federal government's proposed changes to applications for supervised consumption sites, with only five factors to be considered as well as making renewal processes easier.
- Making it easier to establish supervised consumption services by streamlining the federal application process will not only prevent overdose fatalities, it will help connect people into care.
- We absolutely support a consistent, cross-Canada approach to effectively regulate and restrict access to pill presses and tableting machines – which we have consistently pushed for, given that most of these machines are imported and easily transported between provinces.
- And we're pleased that the federal government is mirroring B.C.'s approach with its national Canadian Drugs and Substances Strategy.

- We continue to believe a strong federal response in support of our efforts will be most effective in helping to save lives and we thank the federal government for bolstering the tools in place to combat this crisis.
- And we continue to work with the federal government – in fact, in addition to meetings between the federal and provincial ministers of health, the Mayor of Vancouver and senior government officials late in 2016 as well as staff from the Ministry of Health met with Prime Minister Justin Trudeau just before Christmas to talk about the Joint Task Force plan, the importance of a quick passage for federal Bill C-37, supports for human resources, and a Canada-wide strategy for dealing with surveillance, stigma, prevention, evidence-based research and public safety.
- Anything more the federal government can offer is welcome and appreciated.

Q15. Do the federal actions to date go far enough?

- We are pleased that the federal government is planning to put in place so many of the measures we were calling for them to take action on, and grateful for the funding support they have provided today.
- We have also asked the federal government to do to help us respond to the overdose crisis, including establishing a national overdose surveillance system, enhancing criminal sanctions for production, importation and trafficking of illegal drugs, and adding back resources for RCMP in B.C.
- I expect the new national funding that they have announced today as part of their strategy will assist with that work, and we will continue our discussions with the federal government on these issues.

Supervised Consumption Services

Q16. What is the government doing to establish more supervised consumption services?

- There is very clear evidence of the benefits of supervised consumption services. They reduce the risk of transmitting infectious diseases such as HIV and Hepatitis C, help prevent overdose deaths, and engage marginalized people in the health system.
- All health authorities are actively working on new supervised consumption services. A key part of this process is consultations with the communities with the greatest need for these services.
- We welcome the federal government's proposed changes to the application process for federal exemptions to operate supervised consumption services.

- Streamlining the federal application process will make it easier to establish supervised consumption services so that we can get on with the business of preventing overdose fatalities and helping connect people into the broader system of care so that they can be better supported.
- We hope these changes to the federal legislation will be passed quickly, so that health authorities don't have to go through the currently onerous application process – but we are not waiting.
- Vancouver Coastal Health, Island Health and Fraser Health have submitted applications.
- Health Authorities expect to submit several more applications in early 2017.

Q17. What is the status of health authority applications for supervised consumption services?

- All health authorities are actively working on new supervised consumption services — with most health authorities expecting to submit additional applications to Health Canada in early 2017. A key part of this process is consultations with the communities with the greatest need for these services.

Q18. Status of service expansion:

- Vancouver Coastal Health
    - In October 2016, Vancouver Coastal submitted two applications to Health Canada for SCSs, and an application for a women's only service is being developed. Planning for additional applications is also underway.
    - At present, there are two SCSs in Canada, both operating in Vancouver: Insite is a stand-alone safe injection site in the Downtown Eastside, and the Dr. Peter Centre is a small SCS that is integrated into a multi-service HIV, addiction and housing program.
- Interior Health
    - Following a community consultation process, Interior Health has announced its intention to apply to Health Canada in the coming weeks to operate two mobile SCSs in Kamloops and Kelowna. It is unknown how long it will take for a decision from Health Canada.
    - The locations/service models were selected based on a combination of operational considerations, feedback received from stakeholders and data, which show a high number of overdose deaths in each city.

- Island Health
    - Island Health submitted the first of three planned application for SCSs on Jan. 3, 2017.
    - The location is at 941 Pandora Ave., in a building owned by Island Health. The new service location will be called the Pandora Community Health Centre, which currently delivers a range of public health and mental health and substance use services.
    - Public feedback sessions on proposed new locations in Victoria took place in November, however further discussions continue on the model and scope needed for the Bridge Street location.
    - Island Health has long made public commitments for a minimum of two applications on the South Island.
    - Island Health has prioritized 844 Johnson Street (Johnson Street Community) and 437 Wesley Street (CMHA) in Nanaimo as priorities for the next two SCS applications to go forward.
- Fraser Health
    - Fraser Health is looking at adding its first supervised consumption services locations in Surrey.
    - Fraser Health submitted portions of two applications to Health Canada earlier this year, and just submitted the remaining portions today following completion of their community engagement process.
- Northern Health
    - Northern Health is working to develop a Health Canada application for SCSs in Prince George.
    - Work includes exploring the best way to integrate SCSs with some of the other harm reduction services Northern Health already offers, including a harm-reduction centre that offers needle distribution and recovery.
    - Northern Health will be engaging the local community, downtown businesses and other stakeholders about these plans.

Q19. Will bill C-37 simplify the application process for those health authorities who haven't yet submitted applications? For those that have, will the new legislation be applied retroactively?

- The proposed federal legislative changes would streamline the application process for establishing supervised consumption services to reflect evidence that, properly established and maintained supervised consumption services save lives. The proposed changes would replace the current 26 criteria required to establish a supervised consumption service with five factors set out by the Supreme Court of Canada in its 2011 ruling. However, any applications submitted prior to the new legislation coming into force are expected to be subject to the old rules, though Health Canada has said they will make efforts to expedite reviews.
- Health Canada advised on Feb. 6, 2017 that they will no longer require final on-site inspection of newly constructed or renovated facilities before granting an exemption. For now, applicants are still required to meet all 26 criteria under Bill C-2, but can now be granted an exemption based on site plans only. This means services can begin at a site before renovations or construction is fully complete.
- Health Canada has also posted to its website the list of all pending applications for exemption, the date they were received and from whom and their status.

Overdose Prevention Sites

Q20. Where are the overdose prevention sites located? Who are staffing these sites?

- As of Jan. 25, 2017, there are 20 overdose prevention sites currently open in the hardest-hit areas of the province.
- This includes Vancouver (5), Surrey (2), Maple Ridge (2), Abbotsford (1), Langley (1), Victoria (4), Nanaimo (1) Kamloops (2), Kelowna (1) and Prince George (1).
- These are all locations that have been experiencing significant numbers of overdoses.
- Teams of community staff who are trained in overdose response provide people who use illegal drugs with a safe space to be monitored at these sites.
- Staff are equipped with naloxone and appropriate training for overdose response.

Carfentanil

Q21. How many deaths in B.C. have been caused by carfentanil?

- Carfentanil was found close to one person who suffered an overdose fatality in B.C.; however, the BC Coroners Service was unable to confirm whether carfentanil was the cause of death.

- Lab testing has confirmed that carfentanil is being ingested by people using illegal drugs, through urine tests conducted by LifeLabs.
- The provincial toxicology lab will have the ability to test for carfentanil in overdose fatalities later in March.

Q22. Will B.C. have the ability to test for carfentanil soon?

- Carfentanil testing in B.C.'s provincial toxicology lab was approved by Health Canada, with carfentanil and other fentanyl derivatives added to the Health Canada controlled substances license held by the lab. The lab expects to complete its testing validation soon and begin testing samples later in March.

Q23. When will the backlog at the province's toxicology lab be cleared?

- The toxicology lab is experiencing added demand due to the overdose crisis and they are working with the BC Coroners Service on strategies to deal with this increased demand, including staffing to grow and sustain capacity going forward.
- We understand the coroner expects fentanyl testing results for 2016 to be available in March.

Q24. How will a move to ban carfentanil in China impact the overdose crisis in B.C.?

- We know illicit fentanyl and other opiods are coming into Canada from China. The RCMP and the Chinese Ministry of Public Security are committed to working together to disrupt the supply of these illicit drugs.
- As of March 1, 2017, China is adding carfentanil and three other related synthetic opioids to its list of controlled substances.
- While we don't anticipate that there will be a significant impact to B.C. as a result of this decision, this is good news as it will help stem the flow of the supply of chemicals that are helping to drive the surge in overdoses and deaths.
- Canada and the U.S. have made a commitment to work together to address opioid trafficking, and China's response is encouraging.
- We will continue to work to stop illicit fentanyl and its analogues from entering Canada and targeting those who traffic illegal drugs.

Overdose Victims and Organ Donation

Q25. Does a drug-related overdose death stop someone from being eligible to donate their organs?

- Drug-related overdoses are a serious concern across the continent – my heart goes out to anyone grieving the loss of a loved one.
- One of the great tragedies of this crisis is that it is taking so many young people.
- Because severe brain damage can be one of the consequences of a drug overdose, this does mean that some people who die from an overdose may be suitable for organ donation.
- Drug overdose does not stop someone from becoming an organ donor.

Q26. Is it safe to use organs from people who have died from drug-related overdoses?

- Each donor - no matter the cause of death - is thoroughly screened and assessed prior to organ donation and the transplant team follows a thorough process of informed consent with transplant recipients.
- Physicians will only offer organs that they believe to be safe to recipients, and where the benefits of transplant outweigh the small risk of infection.
- It's heartbreaking anytime someone dies suddenly in a way that makes them a candidate to become an organ donor – and it's also remarkable that the legacy of some of these people is giving the gift of life to someone waiting for a transplant.

Q27. Have transplant numbers increased as a result of the overdose crisis?

- While we have had donors this year who have died from overdoses, the numbers for 2017 still aren't high enough to provide an empirical data analysis of the deceased donors so far this year and how many are related to the ongoing overdose crisis.
- Similarly, it's difficult to make a meaningful comparison between the year-to-date numbers for 2017 compared with 2016, because we're looking at only a six-week period and a relatively small number of donors. We could reasonably expect the numbers to fluctuate over the course of an entire year.

Opioid Substitution Patient Handbook

Q28. What is the opioid substitution patient handbook?

- The handbook, titled "Patients Helping Patients Understand Opioid Substitution Treatment" was released in February 2017 following a series of multi-stakeholder consultations on opioid substitution treatment organized by the Centre for Addictions Research of BC, where the need for such a handbook was repeatedly expressed.
- A number of patients who all have many years of experience with medication-assisted treatments for opioid dependence helped to write the handbook. The Centre for Addictions Research of BC provided coordinating and editing support.

Q29. Why was the handbook developed?

- As part of the overdose crisis response, the province has significantly expanded access to opioid substitution therapies such as methadone and Suboxone over the past number of months.
- Health authorities have also been working to expand access to opioid substitution treatment in response to the overdose emergency, and have increased substance use supports, extended clinic hours and hosted education sessions to support physicians' knowledge on prescribing opioid substitution treatments.
- We recognize how important it is to engage patients and families, so that their perspectives are incorporated into our response to the public health emergency.

Q30. Where can I find the handbook?

- The handbook can be accessed by visiting http://www.uvic.ca/research/centres/carbc/assets/docs/ost-patient.pdf

Q&A

Providence HEALTH CARE
How you want to be treated.

Key messages:

Six main messages

- The results of the ground-breaking SALOME research, published in the Journal of the American Medical Association (JAMA) Psychiatry, show treating chronic heroin addiction now has another effective tool – hyrdomorphone, a licensed pain medication.
- SALOME, which stands for the Study to Assess Longer-term Opioid Medication Effectiveness, found hydromorphone (HDM) to be as effective as diacetylmorphine (pharmaceutical-grade prescription heroin) for people who have not benefited from previous treatments, such as methadone or Suboxone.
- Hydromorphone is a widely available licensed pain medication. Our research demonstrates that it is as effective as diacetylmorphine, emphasizing once again the urgent need to continually seek and provide new treatment options for the most severely heroin-dependent individuals in society.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- Providing injectable opioids in specialized clinics under supervision ensures safety, of the patients and the community, and the provision of comprehensive care.
- As DAM is not presently available in many countries for political and/or regulatory reasons, HDM has a significant advantage as a legal, licensed pain medication. HDM could be offered as a licensed alternative.

SALOME findings

- Injectable hydromorphone is as effective as injectable diacetylmorphine for long-term street opioid users not currently benefitting from available treatments (about 10 per cent of the heroin-dependent population).
- These findings show the importance of having as many treatment options as possible to address the chronic condition of heroin dependence.
- Study participants on both medications reported far fewer days of street-heroin and other opioid use at six months (three to five days per month), compared to almost daily illicit opioid use prior to being enrolled in the study.
- Participants also reported a significant reduction in days of illegal activities (from an average of 14.1 days per month to less than four).
- Almost 80% were retained in treatment at six months.
- Hydromorphone and diacetylmorphine are both safe when taken in a clinical setting. Out of a total of 88,451 injections, there were 14 overdoses and 11 seizures, all successfully managed in the clinic. If these events had occurred in the street, the outcomes may have been fatal.

SALOME / NAOMI background

- The Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) is a clinical study that tests alternative treatments for people with chronic heroin addiction who are not benefiting sufficiently from available treatments such as oral methadone.
- SALOME compared two medications – diacetylmorphine, the active ingredient of heroin, and hydromorphone (HDM), a legal, licensed pain medication.
- The study aims to determine alternative treatments for those currently not benefitting from methadone and other treatments.
- Methadone and Suboxone are effective heroin addiction treatments for many people and should remain the first line response, but there are some people that don't benefit from it.
- The study started in late 2011 and concluded in late 2015. The results have been published in the April 6th edition of the Journal of the American Medical Association (JAMA) Psychiatry.
- The North American Opiate Medication Initiative (NAOMI) was North America's first-ever clinical trial of prescribed heroin that took place from 2005 to 2008. NAOMI tested whether medically prescribed heroin (diacetylmorphine) was more effective than methadone therapy for individuals with chronic heroin addiction who were not benefiting from other conventional treatments.
- In NAOMI, participants treated with diacetylmorphine reported improved physical and mental health, were 62 per cent more likely to remain in addiction treatment and 40 per cent less likely to take illegal drugs and commit crimes to support their habit than were those treated with methadone.
- After a year, 88 per cent of those treated with diacetylmorphine remained in treatment, compared with 54 per cent in the methadone group.
- Data from NAOMI and other long-term studies with medically prescribed heroin show that many of the patients of these studies also transition from injection to oral treatments, detox programs and abstinence.

The addiction

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- A chronic disease is a medical condition for life that can be successfully managed. A person with addiction can regain a healthy, productive life.
- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- The stigma exists because many people don't see heroin addiction as a medical condition; they view it as a choice. But there is no choice for the people whose recovery has failed because treatments have failed.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.

The treatment

- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.
- Both hydromorphone and diacetylmorphine are produced in hygienic pharmaceutical laboratories. They are provided to the patient in a controlled environment, such as a specialized medical clinic, and are then injected by the patient under medical supervision.
- The relapsing nature of this condition means people go through different stages in their drug dependence throughout their life: abstinence, recovery, substitution treatment, etc.
- This is highly dependent on the person's individual circumstances, the social context and the available services in the community.
- As with any other chronic condition, treatment could be needed for life (though this is not the goal).
- Data from long-term studies with diacetylmorphine in Europe and current heroin-assisted treatment programs show many patients transition from injection to oral substitution and also to abstinence while some patients remain on this treatment for years.
- In Switzerland, which now operates 23 heroin-assisted treatment centres throughout the country, more than 40 per cent of those who leave heroin-assisted treatment enter into oral methadone or an abstinence-based program.

The legal case

- Providence and five SALOME patients launched a constitutional challenge to overturn a recent decision by the federal government of Canada that prevents the delivery of life-saving treatment to vulnerable addictions patients.
- On November 13th, 2013, Providence and the five patients filed a Notice of Civil Claim in the BC Supreme Court jointly, requesting, among other things, a declaration that the new federal government regulations infringe on the patients' Charter Rights, are unconstitutional, and should be struck down.
- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- A chronic disease is a medical condition for life. It cannot be cured, but it can be managed. A person with an addiction can regain a healthy, productive life.
- Methadone and Suboxone are effective heroin addiction treatments for many people and should remain the first line response, but there are some people that don't benefit from it.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- Providence doctors applied to Health Canada for special access for 36 participants of SALOME when they finished their 12-month study.
- Health Canada approved 21 patients through its Special Access Programme to continue to use diacetylmorphine.

- On Oct. 3, 2013, within days of the Special Access Programme approvals, Rona Ambrose, Canada's then-Minister of Health, announced that the Conservative government was making immediate changes to ensure diacetylmorphine was no longer eligible for authorization for individual patient use.

The science of Heroin-Assisted Treatment (HAT)

- The science supports this course of treatment. Six similar trials comparing medically-prescribed heroin and methadone (including NAOMI) involving more than 1,500 patients have provided unanimous evidence in support of the effectiveness of this treatment for long-term heroin-dependent individuals.
- Data is available from six countries: Switzerland, the Netherlands, Spain, Germany, the United Kingdom and Canada.
- Heroin-assisted treatment has been officially adopted in the United Kingdom, Switzerland, Germany, Denmark and the Netherlands.

The cost of HAT and Hydromorphone

- Medically prescribed heroin is more cost-effective than methadone for treating long-term street heroin users, according to a recent study published in the Canadian Medical Association Journal (CMAJ).
- The study, which used data from NAOMI, found patients in the MMT group generated an average lifetime societal cost of $1.14 million per person, while those in the heroin (diacetylmorphine)-assisted group generated a lesser cost of $1.09 million.
- The study attributed most of the economic benefits to the fact that recipients of diacetylmorphine stayed in treatment longer and spent less time in relapse than those receiving methadone. Both results are associated with reduced criminal activity and lower health care costs.
- Heroin addiction is extremely expensive. A recent study has shown that treating patients with diacetylmorphine saves money over time.
- A similar cost study will be done for hydromorphone in the near future.

Q&A (Using Key Messages):

1) SALOME Results (Eugenia or Dr. Schechter)

What are the key findings of the study?

- ***In terms of efficiency, in reducing illicit heroin use in chronic injecting-opioid users after six months of treatment?***

- Injectable hydromorphone is as effective as injectable diacetylmorphine for long-term street opioid users not currently benefitting from available treatments (about 10 per cent of the heroin-dependent population).

  These findings show the importance of having as many treatment options as possible to address the chronic condition of heroin dependence.

  Study participants on both medications reported far fewer days of street-heroin and other opioid use at six months (three to five days per month), compared to almost daily illicit opioid use prior to being enrolled in the study.

  Participants also reported a significant reduction in days of illegal activities (from an average of 14.1 days per month to less than four).

  Almost 80% were retained in treatment at six months.

  As DAM is not presently available in many countries for political and/or regulatory reasons, HDM has a significant advantage as a legal, licensed pain medication. HDM could be offered as a licensed alternative.

- ***In terms of safety?***

  Hydromorphone and diacetylmorphine are both safe when taken in a clinical setting. Out of a total of 88,451 injections, there were 14 overdoses and 11 seizures, all successfully managed in the clinic. If these events had occurred in the street, the outcomes may have been fatal.

  Providing injectable opioids in specialized clinics under supervision ensures safety, of the patients and the community, and the provision of comprehensive care.

- ***In terms of blinding and being able to determine what medication they are on?***

  Analysis showed that participants did not correctly guess their treatment arm beyond what is expected by chance, and that the response among those randomized to receive hydromorphone did not show differences compared to those on diacetylmorphine.

How many people overdosed in the study? Seizures? How many died?

- Hydromorphone and diacetylmorphine are both safe when taken in a clinical setting. Out of a total of 88,451 injections, there were 14 overdoses and 11 seizures, all successfully managed in the clinic. If these events had occurred in the street, the outcomes may have been fatal.
- There were four deaths during the 12 month duration of active treatment delivered in SALOME, all were deemed unrelated to the treatment.
- Both drugs were produced in hygienic pharmaceutical laboratories. They were provided to the participants in a controlled specialized medical clinic, and then injected by the participants under medical supervision.
- Illicit heroin is a very dangerous street drug. Because it is of unknown dose and purity, people using the drug face the risk of infection, overdose and death. As it is illegal, many people using heroin avoid health care venues and inject the drug in unsafe circumstances, without medical supervision and potentially without access to clean injection equipment. This places heroin users at high risk of being infected by or transmitting HIV and other blood borne diseases like Hepatitis C. Using poorly controlled drugs in unsafe settings means that users often need emergency medical care or have complicated medical conditions requiring frequent hospitalisation.

2) The SALOME Clinical Trial (Eugenia or Dr. Schechter)

What is SALOME and what are the objectives of this study?

- The Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) is a clinical study that tests alternative treatments for people with chronic heroin addiction who are not benefiting sufficiently from available treatments such as oral methadone.
- SALOME compared two medications – diacetylmorphine, the active ingredient of heroin, and hydromorphone (HDM), a legal, licensed pain medication.
- Studies in Canada and Europe have demonstrated that treatment with diacetylmorphine is more effective than oral methadone for some of the most vulnerable heroin users. HDM has now been shown to be as good as diacetylmorphine and should now become an alternative for those currently not benefitting from methadone and other treatments, and be integrated in the treatment continuum available through licensed doctors.

Who was eligible for SALOME?

- Stringent controls were placed on the screening of participants to ensure that only those who fell within the “chronic” category were selected. The SALOME study defined "chronic" as persons with a history of at least five years of documented drug addiction. As well, participants must have been using heroin frequently for at least one year immediately prior to entry into the study.
- We had specific inclusion and exclusion criteria that were verified by lab testing, health care and pharmacy records to ensure the participation of the right candidates.
- However, there are still hundreds of other patients that meet this criteria that could benefit from receiving hydromorphone or diacetylmorphine.

What about methadone or Suboxone? Aren’t those treatments effective enough?

- Methadone and Suboxone are effective heroin addiction treatments for many people and should remain the first line response, but there are some people that don’t benefit from it.

- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- According to European studies, this applies to only approximately 10 per cent of the opioid-dependent population.

How was the SALOME project conducted?

- SALOME involved two-stages, with each trial participant remaining for six months in each phase. In stage one, half of the 202 participants were randomized to receive injectable diacetylmorphine, while the other half received injectable HDM. This is a double-blind study — neither the participants nor the researchers or clinical team (other than the pharmacy) were aware of which treatment was being administered. In the second stage, half of the participants were randomized to continue injection treatment exactly as in stage one, while the other half switched to the oral equivalent of the same medication (diacetylmorphine or HDM). The oral version was also provided on a double-blind basis.
- However, the oral version was discontinued due to futility. It became clear it would be highly unlikely for non-inferiority of the oral compared to the injectable arm to be concluded.
- Once in the study, participants visited the clinic up to three times per day at which, after a pre-treatment assessment (for safety reasons), they received their medication. After injecting or ingesting their medication, participants were observed until staff determined that it was safe for them to leave. Addiction medicine doctors oversaw and monitored the prescriptions for both groups.
- Throughout the treatment period, an interdisciplinary team of physicians, nurses, social workers and counselors were available to help participants achieve stability in their life, seek employment and find suitable housing. Some primary care services, HIV, Hepatitis C and psychiatric care were also provided. At any time, participants could choose to switch to methadone treatment, to drug-free (abstinence) programs, to detox programs or any other option available.
- A research team conducted individual assessments to determine if the treatments were effective. This team worked closely but independently from the clinical team and had no power over clinical decisions.

Who was supervising this study?

- The SALOME study received scientific approval as well as ethical approval through a peer-reviewed process that included the University of British Columbia/Providence Health Care Ethics Board. SALOME had also obtained permits and exemptions from Health Canada regarding the quality and safety of the medication and the clinical procedures. All of these organizations received yearly reports on the progress of the study. The study had a data and safety monitoring board comprised of independent experts that periodically reviewed the current data and made recommendations.

How was the study funded?

- SALOME received funding from the Canadian Institutes of Health Research (CIHR) and private donors through the fundraising efforts of the InnerChange Foundation and St. Paul's Hospital Foundation. The clinical care provided to participants in the study was funded by Providence Health Care. The total cost of the study was $7.4 Million.

Who made up the SALOME research team?

- The study was headed by the Centre for Health Evaluation and Outcome Sciences (CHÉOS) at Providence Health Care researchers Drs. Eugenia Oviedo-Joekes and Michael Krausz. A leading

addictions researcher, Dr. Oviedo-Joekes worked on a similar heroin prescription trial in Spain as well as Canada's NAOMI project. Dr. Krausz has also worked in another heroin trial in Germany, the largest such randomized clinical trial in Europe.

- The other co-investigators included Dr. Martin T. Schechter (NAOMI's principal investigator), Drs. Aslam H. Anis, Nick Bansback, Suzanne Brissette, Julie Bruneau, and Christian Schultz, and Amin Janmohamed of the University of British Columbia, University of Montreal, and Providence Health Care.

When did the study conclude?

- The study started in late 2011 and concluded in late 2015. The results have been published in the April 6th edition of the Journal of the American Medical Association (JAMA) Psychiatry.

Was mandatory counseling part of the study?

- Study participants were offered and encouraged to participate in support services offered as part of the study.
- Throughout the treatment period, an interdisciplinary team of physicians, nurses, social workers and counselors were available to help participants achieve stability in their life, seek employment and find suitable housing. Some primary care services, HIV, Hepatitis C and psychiatric care were also provided.
- At any time, participants could choose to switch to methadone or suboxone treatment, to drug-free (abstinence) programs, to detox programs or any other option available.

Was SALOME ethical?

- The SALOME protocol received peer-reviewed scientific approval from the Canadian Institutes of Health Research
- It was also reviewed and independently approved by the Ethics Committees of the participating institutions, the Clinical Trial Committee of the Canadian Institute for Health research and by the regulatory branch of Health Canada.

If both DAM and HDM have been shown to be feasible and effective in numerous studies around the world, why did we need to study this more?

- SALOME aimed to determine alternative treatments for people with chronic heroin addiction not benefitting sufficiently from available treatments such as oral methadone.
- This was the world's first study that looks at the effectiveness of HDM as an alternative treatment option for chronic heroin addiction.
- In Canada, the continued use of medically prescribed diacetylmorphine was not previously an option under the Conservative government as doctors were unable to secure approval from the federal government to either set up a permanent heroin-assisted treatment (HAT) clinic, or provide continued access to diacetylmorphine to the participants of studies.

Was it worth it to spend money on this trial?

- Patient care is our first priority. It is also important to note that heroin addiction is extremely expensive and finding a solution will save money over time.
- Heroin addiction affects 60,000 to 90,000 Canadians.
- Every person with severe opioid use disorder left untreated costs taxpayers at least $45,000 per year.

- These costs stem from overdoses, costs such as medical care, public health, policing, criminal justice and jail expenses as well as public disorder and crimes against people and property.

How are SALOME and NAOMI trials related?

- The NAOMI study provided injectable HDM to a small group of participants. An unexpected finding was that many participants couldn't tell the difference between the effects of diacetylmorphine and HDM.
- However, the small number of participants receiving HDM did not permit researchers to draw any definite and scientifically valid conclusions as to the efficacy of HDM as a treatment option.
- Therefore, the SALOME investigators designed a study to test this hypothesis.
- SALOME aimed to determine alternative treatments for people with chronic heroin addiction not benefitting sufficiently from available treatments such as oral methadone.

Where did/does the DAM come from and was it kept in a safe location throughout the study?

- The diacetylmorphine is manufactured in a laboratory by a pharmaceutical company in Europe.
- It is very securely stored.

Did the SALOME study add to public nuisance problems in Vancouver?

- No - In fact, it had the opposite effect. Once people get stabilized they tend to become more orderly.

3) Post-SALOME(Dr. Scott MacDonald or Scott Harrison)

What happened to study participants after they completed their 12-months in the study and before the results of the study were available?

- They were no longer part of the study and become patients of PHC and/or VCH. They were offered ongoing treatment with the resources and medications that were available.
- Participants and their doctor discussed the best treatment plan based on the available options.
- Some of the patients needed diacetylmorphine, as no other treatment had worked for them. That's why Providence doctors started submitting applications to the Special Access Programme (SAP) at Health Canada, requesting that they be allowed to prescribe diacetylmorphine to SALOME participants for compassionate use, which in their clinical judgement was a critical treatment for their patients.
- 110 of these applications have been approved by Health Canada.
- These approvals are limited to a treatment regime of 90 days.
- Other participants were put on either oral or injectable hydromorphone
- Others were transferred to methadone or drug-free and/or detox programs

How many Crosstown patients are currently on hydromorphone? How many are on DAM?

- As of March 16, 2016, there are 110 people receiving diacetylmorphine.

- As of March 16, 2016, there are 25 people receiving injectable hydromorphone.
- As of March 16, 2016, there are 135 people receiving injectable opioid assisted treatment (IOAT). These are the only patients with access to this treatment in all of North America.
- It is estimated that at least 500 people in Vancouver, including those at the Crosstown Clinic, could benefit from IOAT.

Do you have a plan for making hydromorphone treatment legal? What are the steps to do this? How long does it take?

- The results of SALOME were submitted to the Canadian Institutes for Health Research (CIHR) and Health Canada for review as well as published in the April 6th edition of the Journal of the American Medical Association (JAMA) Psychiatry.
- As the results are positive, we are now in a position to pursue the licensing of HDM as a substitution treatment for heroin dependency, adding another option for physicians and their patients alongside existing medication such as methadone, Suboxone and HAT.
- As a shorter-term solution, HDM – currently licensed for use in pain relief – could be prescribed "off-label" as a heroin substitution treatment.
- Doctors outside of PHC will now need to consider if they would be willing to prescribe HDM based on the results of SALOME alone, as international medical evidence is based on Diacetylmorphine (Heroin).

If off-label HDM is available and can be prescribed, why aren't doctors told to prescribe it more to addicts?

- HDM is a licensed pain medication. Doctors may be reluctant to prescribe HDM as it hasn't been approved for heroin addiction treatment and the research has just been completed.
- This is the world's first study that looks at the effectiveness of HDM as an alternative treatment option for chronic heroin addiction.
- However, PHC doctors with experience using this drug have been prescribing it to patients finishing the study and will continue to do so.

Now that the results are in, will other physicians in BC start prescribing hydromorphone? What will it take to get other physicians in BC to start using hydromorphone as another treatment option for the heroin addicted population?

- Discussions occur between the participants and their doctor to determine the best treatment course based on the available options.
- Currently hydromorphone for treating heroin addiction is considered "off-label" use.

Is this treatment effective for other opioid dependencies other than heroin?

- The indication for hydromorphone is 'severe opioid use disorder' as per the DSM's latest version. Hydromorphone would be as effective as DAM for those who inject any kind of opioids in the street.

Did SALOME aim to promote legalization of heroin?

- No one involved in these studies or the lawsuit was advocating for the legalization of heroin or any other illicit drugs.
- The study aimed to determine alternative treatments for people with chronic heroin addiction not benefitting sufficiently from available treatments such as oral methadone.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.

Did SALOME follow up with their participants post-study?

- The research team conducted regular assessments during the study and for six to 24 months post-study. Participants filled in questionnaires about their status (i.e. Addiction Severity Index, use of illicit drugs during the study period, criminal activity, health status).

If we start offering injectable hydromorphone would this make getting SAP approvals from Health Canada impossible as they could suggest that a viable other legal alternative is available?

- It is premature for us to engage in speculations about what Health Canada's response will be in providing SAP approvals.

Why should diacetylmorphine be accessible through the "Special Access Programme"?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- SAP is designed to let patients on an emergency basis for severe and life threatening conditions to get medications not approved in Canada. People living with chronic heroin use disorder are sick. On that basis, Health Canada authorized this treatment.

What is hydromorphone currently licensed for?

- HDM is currently licensed for use in pain relief.

Is hydromorphone available in an oral format?

- Yes, but there is no scientific evidence for its effectiveness as this phase of the SALOME trial was not completed.
- It was not completed because some observations were made that strongly suggested the investigators would be unlikely to demonstrate the non-inferiority of the oral medications: lower retention rates, more missed sessions per day, clinical deterioration observed by study physicians for those participants switched to oral after being stabilized on injection treatment for the previous six months.

Which drug/medication is cheaper? How much do they cost?

- They both cost roughly the same.
- Every person with severe opioid use disorder left untreated costs taxpayers at least $45,000 per year.

- These costs stem from overdoses, costs such as medical care, public health, policing, criminal justice and jail expenses as well as public disorder and crimes against people and property.

How well will hydromorphone work when patients know they will be receiving hydromorphone and not heroin?

- When asked what treatment would you prefer to receive, participants reported a clear preference for injectable DAM compared to injectable HDM. However, while 83.2% wished to be randomized to injectable DAM, when asked if they would enroll in injectable HDM if DAM was not available, 82.2% of the total sample said yes, they would enroll.

What has Health Canada and the federal government's response been to the results of this study

- We cannot speak for Health Canada or the federal government.

Do you need federal government approval to set up new hydromorphone clinics?

No.

Do you think other countries around the world could start using hydromorphone based on the results of this study? Especially, those countries against HAT?

- In jurisdictions where diacetylmorphine is currently not available or for patients where it is contraindicated or unsuccessful, hydromorphone could be offered as a licensed alternative.

Will hydromorphone be funded by provincial government for heroin addiction? What about HAT?

- You will have to ask the provincial government.

When will non-SALOME patients who are not doing well on methadone have access to hydromorphone? HAT?

- Again, this will be determined by the federal government, Health Canada and the province. At this point, it is premature for us to speculate how they will respond to the study results.

4) NAOMI (Eugenia or Dr. Schechter)

What was NAOMI?

- NAOMI was North America's first-ever clinical trial of prescribed heroin that took place from 2005 to 2008.
- It was led by researchers from PHC and UBC, and tested whether medically prescribed heroin (diacetylmorphine) was more effective than methadone therapy for individuals with chronic heroin addiction who were not benefiting from other conventional treatments.

Who participated in the NAOMI study?

- NAOMI enrolled 251 chronic, heroin dependent participants (192 in Vancouver and 59 in Montreal).

Was mandatory counseling part of the study?

- Study participants were offered and encouraged to participate in support services offered as part of the study.

- Throughout the treatment period, an interdisciplinary team of physicians, nurses, social workers and counselors are available to help participants achieve stability in their life, seek employment and find suitable housing. Some primary care services, HIV, Hepatitis C and psychiatric care are also provided.
- At any time, participants can choose to switch to methadone treatment, to drug-free (abstinence) programs, to detox programs or any other option available

Was NAOMI ethical?

- Absolutely. NAOMI was approved by ethical review boards at three Canadian universities, the participating hospitals and others.
- The study was designed by addiction experts from across North America. Injection drug users and patients were also actively involved in planning prior to and throughout the NAOMI study.
- The final design was independently approved by the Clinical Trial Committee of the CIHR, by five institutional Ethics Review Boards, and by the regulatory branch of Health Canada.
- Also all participants were clearly informed on multiple occasions prior to enrollment that the injection medication would not be continued beyond the study period but they would be offered the best available maintenance treatment in their communities.

Didn't participants want higher and higher dosages of diacetylmorphine?

- No. Evidence from NAOMI and other international studies showed doses given to patients did not increase and in fact tend to level off or decrease. The majority of people want to reduce their dependency on medication not increase it.

What did NAOMI find?

- In NAOMI, participants treated with diacetylmorphine reported improved physical and mental health, were 62 per cent more likely to remain in addiction treatment and 40 per cent less likely to take illegal drugs and commit crimes to support their habit than were those treated with methadone.
- After a year, 88 per cent of those treated with diacetylmorphine remained in treatment, compared with 54 per cent in the methadone group.
- Data from NAOMI and other long-term studies with medically prescribed heroin show that many of the patients of these studies also transition from injection to oral treatments, detox programs and abstinence.

I heard NAOMI was flawed. Methadone (MMT) dosages were too low, so of course the outcomes were better for the participants on HAT. Is this true?

- The results were reviewed by the Canadian Institutes for Health Research (CIHR) and Health Canada, as well as submitted for publishing in peer-reviewed journals like the prestigious New England Journal of Medicine.
- The study has passed all scrutiny.

5) NAOMI Post-Study (Eugenia or Dr. Schechter)

What happened to the NAOMI participants after they completed the study?

- Doctors were unable to secure approval from the federal government to give patients diacetylmorphine.
- All participants who received injection medication were encouraged to switch to methadone.

- Providence agreed to provide interim funding for the continued operations of a methadone program at the clinic site. SALOME was designed to continue the work of NAOMI.

Why were SAP applications approved post-SALOME, but not post-NAOMI?

- This is a question for Health Canada. I do not want to speculate.

6) HAT International Studies and Programs (All approved spokespeople)

Have heroin-assisted treatment studies and programs been tried in other countries?

- The science supports this course of treatment. Six similar trials comparing medically-prescribed heroin and methadone (including NAOMI) involving more than 1,500 patients have provided unanimous evidence in support of the effectiveness of this treatment for long-term heroin-dependent individuals.
- Data is available from six countries: Switzerland, the Netherlands, Spain, Germany, the United Kingdom and Canada.
- Heroin-assisted treatment has been officially adopted in the United Kingdom, Switzerland, Germany, Denmark and the Netherlands.

Why didn't Spain implement HAT after their study?

- Four of the six countries that studied this treatment implemented programs. In addition, Denmark implemented a program based on these studies.
- We can't speak on behalf of the Spanish government.

Why didn't Australia implement HAT?

- Four of the six countries that studied this treatment implemented programs. In addition, Denmark implemented a program based on these studies.
- We can't speak on behalf of Australia.

7) Heroin Addiction in Canada(All approved spokespeople)

How serious of a problem is heroin addiction in Canada?In BC?

- Heroin addiction affects 60,000 to 90,000 Canadians.
- The risks include deadly overdoses, life-limiting diseases such as HIV and Hepatitis C, unemployment, social disintegration, violence and crime. Heroin addiction is extremely expensive. Finding a solution will save money over time.
- Every person with severe opioid use disorder left untreated costs taxpayers at least $45,000 per year.These costs stem from overdoses, costs such as medical care, public health, policing, criminal justice and jail expenses as well as public disorder and crimes against people and property.

Why are heroin addicts so stigmatized and why is this harmful?

- The stigma exists because many people don't see heroin addiction as a medical condition; they view it as a choice. But there is no choice for the people whose recovery has failed because treatments have failed.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.

8) Opioid Treatment in General(All approved spokespeople)

What are opioids?

- Doctors prescribe opioid medication to treat pain and some times for other health problems such as severe coughing. The medication comes in a pill, a liquid, or a wafer. It also comes in a patch worn on the skin. Examples of prescribed opioid medications include: codeine, OxyContin, HDM, morphine and methadone.

What are the side effects from taking opioids?

- You can develop a tolerance.
- You can become physically dependent — to feel extremely sick if there are no opioids in the body
- People who have become dependent on opioids medication but are ready to stop taking it can taper off (take less and less) to avoid withdrawal.

Are opioids addictive?

- The pathway to addiction is complex, highly individual and often traumatic. People using heroin have often experienced traumatic events including childhood abuse and neglect, generational trauma from Residential Schools or poverty, dysfunctional family life, lack of access to education, employment and housing and abusive relationships.
- For many users, heroin provides a form of self-medicated relief from both their emotional pain and social reality. Once addicted, heroin users have no choice but to keep on using heroin or experience dangerous withdrawal.

Can opioid addiction be treated?

- Opioid addiction is a chronic illness, like heart disease or diabetes. A chronic disease is a medical condition for life. It cannot be cured, but it can be managed. A person with addiction can regain a healthy, productive life.
- Treatment assists individuals to prevent withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.

9) Heroin-Assisted Treatment (HAT) and HDM(All approved spokespeople)

What is HAT?

- Prescription heroin treatment, known as diacetylmorphine or Heroin-Assisted Treatment (HAT), allows a doctor to prescribe pharmaceutical grade heroin to a patient.
- The drug is produced in a hygienic pharmaceutical laboratory. It is provided to the patient in a controlled environment, such as a specialized medical clinic, and is then injected by the patient under medical supervision.
- Research has unanimously shown that HAT, delivered in a clinical setting with appropriate safeguards and supports, is a more effective treatment for problematic heroin use than oral methadone

Is the intent for people who receive Hydromorphone or HAT to remain on government-supplied opioids for the rest of their lives?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- The relapsing nature of this condition means people go through different stages in their drug dependence throughout their life: abstinence, recovery, substitution treatment, etc.
- This is highly dependent on the person's individual circumstances, the social context and the available services in the community.
- As any other chronic condition, treatment could be needed for life (though this is not the goal).
- Data from long-term studies with diacetylmorphine in Europe and current HAT programs show many patients transition from injection to oral substitution and also to abstinence while some patients remain on this treatment for years.
- In Switzerland, which now operates 23 heroin-assisted treatment centres throughout the country, more than 40 per cent of those who leave HAT enter into an abstinence-based program.

By giving heroin to people, won't you create more people who will have a heroin addiction?

- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.

How is this treatment different from a supervised injection site?

- One of the goals of hydromorphone or heroin assisted treatment is to remove patients from the illegal drug market. Participants receive treatment (hydromorphone or diacetylmorphine - prescribed heroin) as well as social supports, so they will not need to engage in the illicit drug trade to feed their addiction.

- Conversely, supervised injection sites are legally protected places where drug users consume pre-obtained illicit drugs in a safe, non-judgmental environment that also provides health care, counseling, and referrals to other health and social services, including drug treatment.

So you're giving heroin to heroin addicts?

- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- On average, study participants had tried treatment using methadone or other detox programs on average 11 times.

Is it possible to quantify how many people treated with HAT eventually stop needing this treatment?

- In Switzerland, which now operates 23 HAT centres throughout the country, over 40% of those who leave HAT enter into an abstinence-based program.

Shouldn't more resources be devoted to optimising MMT programs first?

- Methadone is an effective heroin addiction treatment for many people and should remain the first line response, but there are some people that don't benefit from it.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.

What about acupuncture? Former Health Minister Rona Ambrose suggested this as a treatment option to be explored.

- The science supports this course of treatment. Six similar trials comparing medically-prescribed heroin and methadone (including NAOMI) involving more than 1,500 patients have provided unanimous evidence in support of the effectiveness of this treatment for long-term heroin-dependent individuals.
- After 35 years of active research by both Asian and Western scientists, there is no quality evidence available that can establish the efficacy of acupuncture in the treatment of opiate addiction.

Methadone is long-lasting, requiring only one dose. Heroin and hydromorphone are short-acting, and generally take multiple daily doses to prevent withdrawal symptoms from emerging. Isn't this a problem?

- Methadone is an effective heroin addiction treatment for many people and should remain the first line response, but there are some people that don't benefit from it.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.

Can people function and work on hydromorphone or HAT?

- Just like methadone, people who are stable on hydromorphone or heroin-assisted treatment should be able to do many job they are otherwise qualified to do. A person stabilized on the correct dose is not

sedated, in withdrawal or euphoric. The most common description of how a person feels on hydromorphone or HAT is “normal.”

This is an increased focus on harm reduction. Don't we need more treatment?

- This is treatment. Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.

Why don't we just ask people to stop using drugs and offer only abstinence treatment?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- A chronic disease is a medical condition for life. It cannot be cured, but it can be managed. A person with addiction can regain a healthy, productive life.
- Data from long-term studies with diacetylmorphine in Europe and current HAT programs show many patients transition from injection to oral substitution and also to abstinence while some patients remain on this treatment for years.
- In Switzerland, which now operates 23 heroin-assisted treatment centres throughout the country, more than 40 per cent of those who leave HAT enter into an abstinence-based program.

Aren’t these programs dangerous? Are you concerned about patient safety?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- Pharmaceutical heroin in its pure form is not harmful to the body; the street drug, however, may be poorly manufactured, stored or transported in infectious conditions, and is often adulterated with unknown and potentially dangerous substances.
- Illicit heroin is a very dangerous street drug. Because it is of unknown dose and purity, people using the drug face the risk of infection, overdose and death. As it is illegal, many people using heroin avoid health care venues and inject the drug in unsafe circumstances, without medical supervision and potentially without access to clean injection equipment. This places heroin users at high risk of being infected by or transmitting HIV and other blood borne diseases like Hepatitis C. Using poorly controlled drugs in unsafe settings means that users often need emergency medical care or have complicated medical conditions requiring frequent hospitalisation.

10) Cost Effectivenessof HAT and HDM(All approved spokespeople)

How much does addiction cost Canadian society?

- Illicit drug use costs approximately 8.2 billion dollars. Every person with severe opioid-use disorder left untreated costs taxpayers at least $45,000 per year.

Does DAM cost more than MMT? If so, how can taxpayers afford it?

- Medically prescribed heroin is more cost-effective than methadone for treating long-term street heroin users, according to a recent study published in the Canadian Medical Association Journal (CMAJ).

- The study, which used data from NAOMI, found patients in the MMT group generated an average lifetime societal cost of $1.14 million per person, while those in the DAM group generated a lesser cost of $1.09 million.
- The study attributed most of the economic benefits to the fact that recipients of DAM stayed in treatment longer and spent less time in relapse than those receiving methadone. Both results are associated with reduced criminal activity and lower health care costs.

Is HDM more expensive then MMT? If so, how can taxpayers afford it?

- We base our decisions on science. We are still studying HDM. We are not at a point where we can answer this question. It would be speculative.
- Every person with severe opioid use disorder left untreated costs taxpayers at least $45,000 per year.

How many people in Vancouver would require a hydromorphone program? BC? Canada? What would the costs be?

- It is difficult to estimate the total number of people that might require this treatment.
- Treatment with hydromorphone or diacetylmorphine under supervision is an intensified treatment option for people who have tried all other treatment options and continue injecting in the street. It is estimated that no more than 10% of all patients receiving substitution treatment will need to be treated in these clinics.
- It is estimated that at least 500 people in Vancouver, including those at the Crosstown Clinic, could benefit from IOAT.
- Diacetylmorphine is more cost-effective than methadone for treating long-term street heroin users, according to a recent study published in the Canadian Medical Association Journal (CMAJ).
- The study, which used data from NAOMI, found patients in the MMT group generated an average lifetime societal cost of $1.14 million per person, while those in the DAM group generated a lesser cost of $1.09 million.
- The study attributed most of the economic benefits to the fact that recipients of DAM stayed in treatment longer and spent less time in relapse than those receiving methadone. Both results are associated with reduced criminal activity and lower health care costs.
- Since HDM and HAT are similarly priced, we can expect that HDM programs will also be cost effective. Studies on this are currently being done.

11) The Future(All approved spokespeople)

Do you think there's a future then for HDM and HAT in Canada?

- Yes, hydromorphone and HAT have a very small but very important role in the addiction treatment system. It would be reserved only be for the most chronic heroin dependent people who are not benefiting sufficiently from current approaches to care.
- The science supports both these courses of treatment.
- For HAT, six similar trials comparing medically-prescribed heroin and methadone (including NAOMI) involving more than 1,500 patients have provided unanimous evidence in support of the effectiveness of this treatment for long-term heroin-dependent individuals.

- For HDM, SALOME has demonstrated that it is just as effective as HAT for the treatment of long-term heroin-dependent individuals.

Do you think there's any way to counteract the stigma around heroin addiction?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- A chronic disease is a medical condition for life. It cannot be cured, but it can be managed. A person with addiction can regain a healthy, productive life.
- Taking medication for heroin addiction is like taking medication to control heart disease or diabetes.
- The stigma exists because many people don't see heroin addiction as a medical condition; they view it as a choice. But there is no choice for the people whose recovery has failed because treatments have failed.
- Treatment assists individuals to get through dangerous withdrawal symptoms, stabilizes their lives and gives them the opportunity to wean themselves off gradually and begin to deal with their underlying psychological and mental health issues that contribute to their addiction.
- Addiction is now globally accepted as an illness, not a choice, however, the lack of reliable information about addiction in the wider community, allows prejudice and stigma to take the place of real facts.
- Of course, we would like to see an end to the number of people addicted to heroin, but for those who already are addicted, it is essential that we provide the very best care based on the very best evidence. Addiction affects individuals, families and communities, all of whom rely on health professionals to do their very best to help people recover.

Health Canada has a "Special Access Programme (SAP)" that is designed to give Canadians with rare diseases or terminal illnesses access to medications that are not otherwise approved for use in Canada. Should heroin treatment be available in this program?

- We need to start recognizing that heroin addiction is a chronic illness, like heart disease or diabetes.
- SAP is designed to let patients on an emergency basis for severe and life threatening conditions to get medications not approved in Canada. People living with chronic heroin use disorder are sick. On that basis, Health Canada authorized this treatment.

12) Legal Challenge(Scott Harrison or Dr. Scott MacDonald)

Why did Providence take legal action?

- Providence was very concerned that because the former Conservative government's decision to amend the regulatory regime, made it impossible to access scientifically validated treatment through the SAP, many of our patients lost the health gains they made throughout the study and most were likely to relapse to the use of illicit heroin. For many, this was a death sentence.
- Illicit heroin is a very dangerous street drug. Because it is of unknown dose and purity, people using the drug face the risk of infection, overdose and death. As it is illegal, many people using heroin avoid health care venues and inject the drug in unsafe circumstances, without medical supervision and potentially without access to clean injection equipment. This places heroin users at high risk of being infected by or transmitting HIV and other blood borne diseases like Hepatitis C. Using poorly controlled drugs in unsafe settings means that users often need emergency medical care or have complicated medical conditions requiring frequent hospitalisation.
- Providence felt it was unethical to do nothing to fight for the human rights of one of Canada's most vulnerable groups of people. Providence's mission states that as a Catholic health care community we

must respect the sacredness of all aspects of life. To us, this includes the lives of those most vulnerable individuals in society; those who are suffering from long term heroin addiction.

- This community has very limited life-sustaining treatment options (the available options have failed) and consequently are often marginalized from both the health care system and from wider society.
- At Providence we feel a moral obligation to see the humanity in all people, embrace this community, bring them back into society and explore all the options that may enable them to live healthier, meaningful lives within the larger community.
- This legal action was true to our values and belief in social justice. The ultimate goal of our care is to give those who are ill, through our care, a reason to hope.

Who was involved in the legal challenge?

- On November 13, 2013, Providence and five SALOME patients launched a constitutional challenge to overturn the decision by the former Conservative government of Canada that prevents the delivery of life-saving treatment to vulnerable addictions patients.
- Providence and the five patients filed a Notice of Civil Claim in the BC Supreme Court jointly, requesting, among other things, a declaration that the Conservative government's regulations infringe on the patients' Charter Rights, are unconstitutional, and should be struck down.
- The patient plaintiffs are David Murray, Deborah Bartosch, Larry Love, Douglas Lidstrom and Charles English.
- Along with the declaration, the individuals and Providence successfully asked the court to strike down the regulations and allow the SAP applications for SALOME participants to be considered under the old regulations until the constitutional issues are determined by the court.
- Providence has retained Joseph Arvay as legal counsel in the court action. The patients joining the action are represented by Pivot Legal Society. Arvay is a renowned Canadian lawyer who has argued numerous landmark cases involving civil liberties and constitutional rights, including Vancouver's Supervised Injection Site case in the Supreme Court of Canada.

What legal action are Providence and the SALOME patients taking?

- Providence and five SALOME patients launched a constitutional challenge to overturn a decision by the former Conservative government of Canada that prevents the delivery of life-saving treatment to vulnerable addictions patients.
- We filed a Notice of Civil Claim in the BC Supreme Court jointly, requesting, among other things, a declaration that the changed federal government regulations infringe on the patients' Charter Rights, are unconstitutional, and should be struck down.
- The legal action came in the wake of then Federal Minister of Health Rona Ambrose's October 3, 2013 changes to federal regulations making diacetylmorphine a restricted substance under the Food and Drug Act, preventing it from being available through Health Canada's Special Access Programme (SAP).
- SAP is designed to let patients get medications normally not available in Canada on the basis of credible data supporting the use safety and efficacy of the drug for the medical emergency at issue. This access is limited to patients with serious or life-threatening conditions on a compassionate or emergency basis when conventional therapies have failed, are unsuitable, or are unavailable.
- Through SAP, Providence doctors had requested – and received – access to diacetylmorphine for 21 of the participants exiting the SALOME research study in Vancouver, before the regulations closed off access to this treatment.

Providence and the SALOME patients were granted an injunction, what does this mean?

- The injunction allows doctors associated with Providence's Crosstown Clinic to apply for access to diacetylmorphine to Health Canada's SAP on behalf of participants exiting the study while the constitutional challenge is before the courts

Who was affected by the injunction?

- SALOME research participants who exited the study and wanted access to diacetylmorphine and for whom diacetylmorphine is a medically indicated treatment.
- The injunction granted by the BC Supreme Court was granted in May 2014.

When is the upcoming court date?

October 2016.

How is this legal challenge being paid for?

Providence will not use taxpayer or operational funding to pay the legal fees.

Did the Catholic Church support this legal challenge?

- This legal challenge has the support of Providence's Board, society and the Roman Catholic Archdiocese of Vancouver, which understands the issues and recognizes its value.

Will PHC continue with this legal challenge based on these new findings from SALOME?

- Our position continues to be that DAM should be accessible through the SAP.
- For those patients who only respond to DAM it is imperative that the regulations that were opposed by the previous federal government be reversed.
- We are cautiously optimistic that the new federal government would be responsive to that urgent need.
- Our decision on the court case will be guided by those actions.

Have you had any conversations with the new federal government about this?

Yes we have reaffirmed our position with them.

Will heroin-assisted treatment be legalized under the new federal government?

- You will have to speak to the federal government.

13) Hydromorphone vs HAT(Scott Harrison or Dr. Scott MacDonald)

If hydromorphone is just as effective as heroin, but has less adverse events, will all patients be switched to hydromorphone? Is heroin still needed?

- The results of the ground-breaking SALOME research show treating chronic heroin addiction now has another effective tool – hyrdomorphone, a licensed pain medication.
- It is important for physicians to have a number of tools available to effectively treat chronic medical conditions.
- Patient care is reviewed regularly and decisions are made on an individual basis.

How do you determine if a patient should receive HAT vs Hydromorphone?

- Participants and their doctor discuss the best treatment plan based on the available options.
- Currently, the only patients receiving HAT have SAP from Health Canada. If the legislation changes to include HAT as a treatment option for all heroin addicted patients, then those protocols would be determined based on discussions and consultations with all stakeholders involved.

From:	Emerson, Brian P HLTH:EX
To:	Newton, Sarah GCPE:EX; Henry, Bonnie HLTH:EX
Cc:	Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject:	RE: For review: IN - Opioid Substitution Treament Report
Date:	Thursday, March 9, 2017 5:47:39 PM
Attachments:	IN_OST Report_March8_2017_DRAFT BE.docx

Hi Sarah. Please see my suggestions on the attached.
The most substantive suggestion is to differentiate the causes of this "very complex issue involving many social factors" alluded to in your original first bullet in the "Advice" section, from comprehensive response that is needed, which is what was described in that first bullet.
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

From: Newton, Sarah GCPE:EX
Sent: Thursday, March 9, 2017 9:54 AM
To: Emerson, Brian P HLTH:EX; Henry, Bonnie HLTH:EX
Cc: Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject: RE: For review: IN - Opioid Substitution Treament Report

Hi Brian and Bonnie,

No rush on this one at all, just checking in to see whether you've had a chance to review the attached IN as of yet. Thanks!

Sarah

From: Newton, Sarah GCPE:EX
Sent: Monday, March 6, 2017 2:32 PM
To: Emerson, Brian P HLTH:EX; Henry, Bonnie HLTH:EX; Paton, Arlene HLTH:EX
Cc: Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject: For review: IN - Opioid Substitution Treament Report

Good afternoon,

Please review the attached IN on the upcoming opioid substitution treatment report. Please let me know if you have any changes by end of day Wednesday, if possible. Thanks!

Sarah Newton
Government Communications & Public Engagement
B.C. Ministry of Health
Mobile: 250.213.1703 **| Email:** sarah.newton@gov.bc.ca

From:	Newton, Sarah GCPE:EX
To:	Emerson, Brian P HLTH:EX; Henry, Bonnie HLTH:EX
Cc:	Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject:	RE: For review: IN - Opioid Substitution Treament Report
Date:	Thursday, March 9, 2017 9:54:24 AM
Attachments:	IN_OST Report_March8_2017_DRAFT.docx

Hi Brian and Bonnie,

No rush on this one at all, just checking in to see whether you've had a chance to review the attached IN as of yet. Thanks!

Sarah

From: Newton, Sarah GCPE:EX
Sent: Monday, March 6, 2017 2:32 PM
To: Emerson, Brian P HLTH:EX; Henry, Bonnie HLTH:EX; Paton, Arlene HLTH:EX
Cc: Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject: For review: IN - Opioid Substitution Treament Report

Good afternoon,

Please review the attached IN on the upcoming opioid substitution treatment report. Please let me know if you have any changes by end of day Wednesday, if possible. Thanks!

Sarah Newton
Government Communications & Public Engagement
B.C. Ministry of Health
Mobile: 250.213.1703 **| Email:** sarah.newton@gov.bc.ca

From:	Newton, Sarah GCPE:EX
To:	Emerson, Brian P HLTH:EX; Henry, Bonnie HLTH:EX; Paton, Arlene HLTH:EX
Cc:	Wright, Kristin J HLTH:EX; Berkes, Andrea HLTH:EX; Barnes, Renee A HLTH:EX; Cascaden, Lori R GCPE:EX; Lawrie, Hannah GCPE:EX; Plank, Sarah GCPE:EX
Subject:	For review: IN - Opioid Substitution Treament Report
Date:	Monday, March 6, 2017 2:32:21 PM
Attachments:	IN_OST Report_March6_2017_DRAFT.docx

Good afternoon,

Please review the attached IN on the upcoming opioid substitution treatment report. Please let me know if you have any changes by end of day Wednesday, if possible. Thanks!

Sarah Newton

Government Communications & Public Engagement

B.C. Ministry of Health

Mobile: 250.213.1703 **| Email:** sarah.newton@gov.bc.ca

From:	Newton, Sarah GCPE:EX
To:	Cascaden, Lori R GCPE:EX
Cc:	Plank, Sarah GCPE:EX; Lawrie, Hannah GCPE:EX; Anderson, Kristy GCPE:EX
Subject:	For binder: IN - OST, KM - Prescription Heroin
Date:	Friday, March 3, 2017 3:49:26 PM
Attachments:	IN_Opioid Substitution Treatment_March 3_2017_FINAL.docx KM_Access to prescription heroin_March3 2017 FINAL.docx

Lori,

For the binder. Updated messaging in the attached (just replaced the following bullet):

- **Since Oct. 1, 2016, the BCCSU has hosted 17 training sessions throughout the province with more than 800 health-care providers at 14 locations throughout the province on how best to treat patients who struggle with opioid addiction – in particular how to safely and appropriately prescribe Suboxone.**

(FYI – also updated in the Factsheet on Actions to Prevent OD, Master Q&A, IN on OST Report, IN on Addictions Treatment Wait Times, KM on Access to Opioid Sub Treatment.)

Sarah Newton

Government Communications & Public Engagement

B.C. Ministry of Health

Mobile: 250.213.1703 **| Email:** sarah.newton@gov.bc.ca

From:	Newton, Sarah GCPE:EX
To:	Maloney, Christine GCPE:EX
Subject:	RE: Health Media Summary - Tues Feb 28
Date:	Tuesday, February 28, 2017 4:04:12 PM

Thanks, Christine!

From: Maloney, Christine GCPE:EX
Sent: Tuesday, February 28, 2017 4:03 PM
Subject: Health Media Summary - Tues Feb 28

Ted Field - Global TV | BC
ISSUE: Plasma
STATUS: Provided Background

- Sent audio from scrum

Yvonne Raymond - CTV Vancouver Island - Victoria
ISSUE: MEDIA REQUEST - MAID - Yvonne Raymond - CTV News - DL FEB 28 4PM
STATUS: Referred to Third Party

- Referred to coroner

Anais Elboujdaïni - CBC - Radio Canada
ISSUE: MEDIA REQUEST - PAY FOR PLASMA - Anais Elboujdaïni - Radio Canada - DL FEB 28 4PM
STATUS: Provided Background

- sent scrum audio

Melissa Shaw - Roundhouse Radio 98.3 FM
ISSUE: MEDIA REQUEST - PAY FOR PLASMA - Melissa Shaw - Roundhouse Radio - DL FEB 28 4PM
STATUS: Provided Statement

- Gave MTL Scrum audio

Katie Engqvist - Goldstream Gazette (West Shore - Victoria)
ISSUE: Naloxone Pricing
STATUS: Provided Background

- We know that the overdose crisis is taking a toll on communities and families throughout B.C., including Victoria. We are doing everything we can to keep British Columbians safe, including expanding access to life-saving naloxone.
  We are not able to provide the cost of a single naloxone kit for the Take Home Naloxone Program, to ensure that B.C. continues to get the best price possible and for competitive procurement reasons. There was a modest increase to the cost of

naloxone when B.C. had to switch to a new supplier within the last few months – the BC Centre for Disease Control's current contracted supplier of Naloxone is Teligent. Kaleo is not currently a contracted supplier.
We invested approximately $1 million in the Take Home Naloxone program in 2016, and recent estimates indicate that more than 16,500 no-charge naloxone kits were distributed in 2016, with training on their use also provided. Naloxone kits and training are also available in 458 sites across B.C. – including 58 emergency departments, and 10 correctional facilities.
Police and RCMP supply the kits for their officers, but the province has provided $1.1 million to help cover the cost of the intranasal naloxone and training for police departments as part of the $5 million for the Joint Task Force work (this more expensive form of naloxone is being used by police because their operational requirements preclude carrying needles due to the nature of their work).
For others who would like to have a naloxone kit on-hand, one can be purchased at many pharmacies for about $50 a kit. Those purchasing a kit will be given instructions by the pharmacist on how to use it, and training is also available online at towardtheheart.com

Maria Weisgarber - CTV News (BC)
ISSUE: CIHI Wait Times Report
STATUS: Provided Background

- Will catch Minister in the Halls.

Justine Hunter - Globe and Mail (BC Bureau)
ISSUE: Retirement Concepts
STATUS: Declined to Comment

- Declined

Megan Devlin - CBC - Vancouver
ISSUE: Student physicians on opioids
STATUS: Provided Background

- The opioid overdose crisis claimed more than 900 lives last year, and it has had a profound impact on communities throughout B.C. We recognize that this is a complex issue, and we are taking action by committing ongoing resources to tackle this crisis on many fronts.
  This includes immediate short-term harm-reduction actions and emergency response measures, including significantly expanding access to naloxone (more than 22,000 take-home naloxone kits have been dispensed), implementing 20 overdose prevention sites in the hardest-hit areas of the province, working to increase the number of supervised consumption services (Vancouver Coastal Health, Island Health and Fraser

Health have submitted applications) as well as providing added resources to BC Emergency Health Services.

We are also taking action to provide better supports for treatment and recovery, including opening 60 additional substance use treatment beds and 50 outpatient treatment spaces in addition to the promised 500 new substance use treatment beds, with almost 400 open to date and the remainder to be open by March 31st. We are expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.

To ensure an effective and informed system of care, we established the new BC Centre on Substance Use in 2016. The centre is focused on education for health care practitioners, clinical research on evidence-based substance use treatments and developing clinical treatment guidelines for a range of substance use disorders. The work of the centre will help ensure that the treatment system is effective, based on the latest evidence and serviced by health professionals who are trained on the latest protocols.

In recognition that a stronger cross-government approach is required for the mental-health services across the system of care, a number of provincial ministries and service agencies will be working closely together over the next year to better link services to meet the needs of patients and families. We're taking important steps to better coordinate mental health and substance use services and break down barriers to help people connect to the services they need more quickly. This will be supported by the introduction of specialized mental health and substance use community care programs established by health authorities across B.C. These specialized community services will provide patients with a single point of contact for intake and assessment, and will ensure services are coordinated.

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment, and Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies. However, more work needs to be done to gain a better understanding of how the evidence for supporting the use of injectable diacetylmorphine and hydromorphone as frontline treatment for opioid use disorder can be practically applied and implemented across B.C. B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients.

We also recognize that chronic pain is very difficult to deal with, and that's why we support programs and services to help individuals manage it. At a Pain BC summit held earlier this month, I had the opportunity to connect with experts and professionals and offer our continued support for improving management of chronic pain and exploring the possibility of a provincial pain strategy. We have also provided more than $500,000 to Pain BC and over $2 million to Self-Management BC in 2016/17 to work with

patients and their families to manage chronic pain, among other conditions.
Budget 2017 committed $165 million for a range of targeted initiatives totalling $140 million over three years to support those with mental-health and substance-use challenges, and the Province has earmarked approximately $100 million for measures supporting the overdose crisis response since the public-health emergency was announced in April. This includes enforcement actions under the Province's Guns and Gangs Strategy, additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.
More information about our actions to combat this crisis can be found in our latest release: https://news.gov.bc.ca/releases/2017CFD0003-000369

Matthew Robinson - Province
ISSUE: Confirming Minister Lake Invite
STATUS: Provided Background

- Minister Lake was not aware of a request for him to join Minister Philpott on the tour. However, given he had commitments in the afternoon in Kamloops and a flight back home immediately following the announcement, he was unable to participate.

Allya Davidson - CTV - Toronto
ISSUE: Negligence in Nursing Homes
STATUS: Provided Background

- In B.C., there are a number of ways to resolve concerns about home and community care services. If someone believe their concerns have not been addressed by those providing care, there are several options available for pursuing timely resolution of problems or making a formal complaint.
  Under B.C.'s Community Care and Assisted Living Act (CCLA) – http://www.bclaws.ca/civix/document/id/complete/statreg/02075_01, there are a number of measures that medical health officers or the Assisted Living Registrar can take if a facility is not in compliance with the Act. This can include suspending admissions to the facility, attaching terms and conditions to their license to operate, and, if necessary, suspending or cancelling the license for the care facility. If the issue is a criminal matter, the health authority would also work with appropriate law enforcement officials on the investigation.
  There are offence provisions in the CCALA such as operating without a valid licence or a valid registration in the case of assisted living. They are in section 33 of the act. As well, there are offence provisions for inducing a person to alter a will, make a gift, provide a benefit for a licensee, their spouse relative or friend, require a person entering care to make a donation or payment as a condition of admission, acting as a person of authority or representative of the estate or acting as a representative under the

Representation Agreement Act. If action needs to be taken from any of these offence and penalty provisions it would be Crown Counsel who must bring these forward, after receiving the Report to Crown Counsel from the appropriate investigative agency. Health authorities have used these powers in situations where facilities have not been in compliance – an example of this Summerland Seniors Village in late 2012. Interior Health conducted an operational review, temporarily suspended admissions to the facility, placed conditions on their license, and placed an administrator at the site. When the site was determined to be in compliance with the Act, admissions were allowed again in mid-2013. The site has operated with few complaints since those changes.

From:	Cascaden, Lori R GCPE:EX
To:	Plank, Sarah GCPE:EX; XT:Wilson, Gavin HLTH:IN; Anderson, Kristy GCPE:EX
Cc:	XT:HLTH Adams, Clay
Subject:	RE: Vice Interview request re Crosstown
Date:	Tuesday, February 28, 2017 3:35:00 PM
Attachments:	MR_022717_Megan Devlin_VICE_UBC med students_DRAFT.docx

Attached.

Thanks,

Lori

From: Plank, Sarah GCPE:EX
Sent: Tuesday, February 28, 2017 3:32 PM
To: XT:Wilson, Gavin HLTH:IN; Anderson, Kristy GCPE:EX; Cascaden, Lori R GCPE:EX
Cc: XT:HLTH Adams, Clay
Subject: RE: Vice Interview request re Crosstown

We just responded to Vice as well. Lori can you please share with Gavin what we provided? I presume it was the same reporter? Thanks, Sarah.

From: Wilson, Gavin [CORP] [mailto:Gavin.Wilson@vch.ca]
Sent: Tuesday, February 28, 2017 3:28 PM
To: Anderson, Kristy GCPE:EX; Cascaden, Lori R GCPE:EX
Cc: Plank, Sarah GCPE:EX; XT:HLTH Adams, Clay
Subject: FW: Vice Interview request re Crosstown

from PHC

Date: Feb. 28

Outlet: VICE online, Toronto

Reporter: Rachel Browne

Contact info: rachel.browne@vice.com 905-464-1822

Topic: A look at Crosstown that would include the logistics of acquiring the prescription heroin from Switzerland. Reporter also wants to speak with a patient. Eugenia Oviedo-Joekes likely to do this interview.

Deadline: Wants to wrap up interviews by this Friday. Piece to be published likely next week, exact date TBD.

Ann

From:	Cascaden, Lori R GCPE:EX
To:	Plank, Sarah GCPE:EX
Cc:	Newton, Sarah GCPE:EX
Subject:	RE: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27
Date:	Monday, February 27, 2017 6:18:10 PM

☺

From: Plank, Sarah GCPE:EX
Sent: Monday, February 27, 2017 6:17 PM
To: Cascaden, Lori R GCPE:EX
Cc: Newton, Sarah GCPE:EX
Subject: Re: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Too late - but yes. :)

Sarah Plank

Communications Director | Ministry of Health

Government Communications & Public Engagement

Mobile: 250.208.9621 | Email:sarah.plank@gov.bc.ca

Sent from my iPhone

On Feb 27, 2017, at 4:21 PM, Cascaden, Lori R GCPE:EX <Lori.Cascaden@gov.bc.ca> wrote:

Are we good with this addition?

Lori

From: Chan-Kent, Marissa HLTH:EX
Sent: Monday, February 27, 2017 4:04 PM
To: Cascaden, Lori R GCPE:EX
Cc: Anderson, Kristy GCPE:EX; O'Brien, Kellie HLTH:EX; Plank, Sarah GCPE:EX
Subject: RE: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Can you please reference that the expansion of crosstown clinic requires thoughtful study and our focus on other treatment methods such as suboxone and methadone come first.

Tack onto this paragraph:

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment. Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.

From: Cascaden, Lori R GCPE:EX
Sent: Monday, February 27, 2017 3:10 PM
To: Chan-Kent, Marissa HLTH:EX
Cc: Anderson, Kristy GCPE:EX; O'Brien, Kellie HLTH:EX; Plank, Sarah GCPE:EX
Subject: FW: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Hi Marissa – for secondary please. Noting this is due for 4:00 if we can make that happen.

Thanks,

Lori

Reporter

Megan Devlin, Producer
VICE Canada
MegKDevlin@Gmail.com
226-448-6567 c: 226-448-6567

Deadline Monday, February 27, 2017

Request

I'm writing a piece for Vice Canada on the UBC medical students who are travelling to Victoria today to meet with MLAs to ask for action on the opioid crisis. I've attached their press release here.

Could health minister Terry Lake comment on the asks from these medical students?

Please note the request is for VICE Canada

Background

Recommendation

The opioid overdose crisis claimed more than 900 lives last year, and it has had a profound impact on communities throughout B.C. We recognize that this is a complex issue, and we are taking action by committing ongoing resources to tackle this crisis on many fronts.

This includes immediate short-term harm-reduction actions and emergency response measures, including significantly expanding access to naloxone (more than 22,000 take-home naloxone kits have been dispensed), implementing 20 overdose prevention sites in the hardest-hit areas of the province, working to increase the number of supervised consumption services (Vancouver Coastal Health, Island Health and Fraser Health have submitted applications) as well as providing added resources to BC Emergency Health Services.

We are also taking action to provide better supports for treatment and recovery, including opening 60 additional substance use treatment beds and 50 outpatient treatment spaces in addition to the promised 500 new substance use treatment beds, with almost 400 open to date and the remainder to be open by March 31st. We are expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.

To ensure an effective and informed system of care, we established the new BC Centre on Substance Use in 2016. The centre is focused on education for health care practitioners, clinical research on evidence-based substance use treatments and developing clinical treatment guidelines for a range of substance use disorders. The work of the centre will help ensure that the treatment system is effective, based on the latest evidence and serviced by health professionals who are trained on the latest protocols.

In recognition that a stronger cross-government approach is required for the mental-health services across the system of care, a number of provincial ministries and service agencies will be working closely together over the next year to better link services to meet the needs of patients and families. We're taking important steps to better coordinate mental health and substance use

services and break down barriers to help people connect to the services they need more quickly. This will be supported by the introduction of specialized mental health and substance use community care programs established by health authorities across B.C. These specialized community services will provide patients with a single point of contact for intake and assessment, and will ensure services are coordinated.

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment. Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.

We also recognize that chronic pain is very difficult to deal with, and that's why we support programs and services to help individuals manage it. At a Pain BC summit held earlier this month, I had the opportunity to connect with experts and professionals and offer our continued support for improving management of chronic pain and exploring the possibility of a provincial pain strategy. We have also provided more than $500,000 to Pain BC and over $2 million to Self-Management BC in 2016/17 to work with patients and their families to manage chronic pain, among other conditions.

Budget 2017 committed $165 million for a range of targeted initiatives totalling $140 million over three years to support those with mental-health and substance-use challenges, and the Province has earmarked approximately $100 million for measures supporting the overdose crisis response since the public-health emergency was announced in April. This includes enforcement actions under the Province's Guns and Gangs Strategy, additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.

More information about our actions to combat this crisis can be found in our latest release:
https://news.gov.bc.ca/releases/2017CFD0003-000369

From:	Cascaden, Lori R GCPE:EX
To:	Newton, Sarah GCPE:EX; Plank, Sarah GCPE:EX
Subject:	RE: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27
Date:	Monday, February 27, 2017 4:32:00 PM

Thanks SN. Is SP OK with these?

Lori

From: Newton, Sarah GCPE:EX
Sent: Monday, February 27, 2017 4:30 PM
To: Cascaden, Lori R GCPE:EX; Plank, Sarah GCPE:EX
Subject: RE: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Lori – made some edits using approved language from last week's prescription heroin MR. I believe that this is what Marissa is referencing. Tracked changes in the Word doc.

Reporter

Megan Devlin, Producer
VICE Canada
MegKDevlin@Gmail.com
226-448-6567 c: 226-448-6567

Deadline Monday, February 27, 2017 2:30 PM

Request
I'm writing a piece for Vice Canada on the UBC medical students who are travelling to Victoria today to meet with MLAs to ask for action on the opioid crisis. I've attached their press release here.

Could health minister Terry Lake comment on the asks from these medical students?

Please note the request is for VICE Canada

Background

Recommendation

The opioid overdose crisis claimed more than 900 lives last year, and it has had a profound impact on communities throughout B.C. We recognize that this is a complex issue, and we are taking action by committing ongoing resources to tackle this crisis on many fronts.

This includes immediate short-term harm-reduction actions and emergency response measures, including significantly expanding access to naloxone (more than 22,000 take-home naloxone kits have been dispensed), implementing 20 overdose prevention sites in the hardest-hit areas of the province, working to increase the number of supervised consumption services (Vancouver Coastal Health, Island Health and Fraser Health have submitted applications) as well as providing added resources to BC Emergency Health Services.

We are also taking action to provide better supports for treatment and recovery, including opening 60 additional substance use treatment beds and 50 outpatient treatment spaces in addition to the promised 500 new substance use treatment beds, with almost 400 open to date and the remainder

st

to be open by March 31 . We are expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.

To ensure an effective and informed system of care, we established the new BC Centre on Substance Use in 2016. The centre is focused on education for health care practitioners, clinical research on evidence-based substance use treatments and developing clinical treatment guidelines for a range of substance use disorders. The work of the centre will help ensure that the treatment system is effective, based on the latest evidence and serviced by health professionals who are trained on the latest protocols.

In recognition that a stronger cross-government approach is required for the mental-health services across the system of care, a number of provincial ministries and service agencies will be working closely together over the next year to better link services to meet the needs of patients and families. We're taking important steps to better coordinate mental health and substance use services and break down barriers to help people connect to the services they need more quickly. This will be supported by the introduction of specialized mental health and substance use community care programs established by health authorities across B.C. These specialized community services will provide patients with a single point of contact for intake and assessment, and will ensure services are coordinated.

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment, and Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies. However, more work needs to be done to gain a better understanding of how the evidence the supporting use of injectable diacetylmorphine and hydromorphone for the treatment of opioid use disorder can be practically applied and implemented in B.C. B.C.'s newly-released opioid treatment guidelines developed by the BC Centre on Substance Use focus on first-line treatments such as Suboxone and methadone – treatments that work well for the majority of patients.

We also recognize that chronic pain is very difficult to deal with, and that's why we support programs and services to help individuals manage it. At a Pain BC summit held earlier this month, I had the opportunity to connect with experts and professionals and offer our continued support for improving management of chronic pain and exploring the possibility of a provincial pain strategy. We have also provided more than $500,000 to Pain BC and over $2 million to Self-Management BC in 2016/17 to work with patients and their families to manage chronic pain, among other conditions.

Budget 2017 committed $165 million for a range of targeted initiatives totalling $140 million over three years to support those with mental-health and substance-use challenges, and the Province has earmarked approximately $100 million for measures supporting the overdose crisis response since the public-health emergency was announced in April. This includes enforcement actions under the Province's Guns and Gangs Strategy, additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.

More information about our actions to combat this crisis can be found in our latest release: https://news.gov.bc.ca/releases/2017CFD0003-000369

From: Cascaden, Lori R GCPE:EX
Sent: Monday, February 27, 2017 4:21 PM
To: Plank, Sarah GCPE:EX; Newton, Sarah GCPE:EX

Subject: FW: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Are we good with this addition?

Lori

From: Chan-Kent, Marissa HLTH:EX
Sent: Monday, February 27, 2017 4:04 PM
To: Cascaden, Lori R GCPE:EX
Cc: Anderson, Kristy GCPE:EX; O'Brien, Kellie HLTH:EX; Plank, Sarah GCPE:EX
Subject: RE: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Can you please reference that the expansion of crosstown clinic requires thoughtful study and our focus on other treatment methods such as suboxone and methadone come first.

Tack onto this paragraph:

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment. Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.

From: Cascaden, Lori R GCPE:EX
Sent: Monday, February 27, 2017 3:10 PM
To: Chan-Kent, Marissa HLTH:EX
Cc: Anderson, Kristy GCPE:EX; O'Brien, Kellie HLTH:EX; Plank, Sarah GCPE:EX
Subject: FW: MEDIA REQUEST - UBC Medical students - Megan Devlin - VICE - DL Feb 27

Hi Marissa – for secondary please. Noting this is due for 4:00 if we can make that happen.

Thanks,

Lori

Reporter

Megan Devlin, Producer
VICE Canada
MegKDevlin@Gmail.com
226-448-6567 c: 226-448-6567

Deadline Monday, February 27, 2017

Request
I'm writing a piece for Vice Canada on the UBC medical students who are travelling to Victoria today to meet with MLAs to ask for action on the opioid crisis. I've attached their press release here.

Could health minister Terry Lake comment on the asks from these medical students?

Please note the request is for VICE Canada

Background

Recommendation

The opioid overdose crisis claimed more than 900 lives last year, and it has had a profound impact on communities throughout B.C. We recognize that this is a complex issue, and we are taking action by committing ongoing resources to tackle this crisis on many fronts.

This includes immediate short-term harm-reduction actions and emergency response measures, including significantly expanding access to naloxone (more than 22,000 take-home naloxone kits have been dispensed), implementing 20 overdose prevention sites in the hardest-hit areas of the province, working to increase the number of supervised consumption services (Vancouver Coastal Health, Island Health and Fraser Health have submitted applications) as well as providing added resources to BC Emergency Health Services.

We are also taking action to provide better supports for treatment and recovery, including opening 60 additional substance use treatment beds and 50 outpatient treatment spaces in addition to the promised 500 new substance use treatment beds, with almost 400 open to date and the remainder to be open by March 31st. We are expanding access to opioid substitution therapies like Suboxone and supporting the work of the BC Centre on Substance Use.

To ensure an effective and informed system of care, we established the new BC Centre on Substance Use in 2016. The centre is focused on education for health care practitioners, clinical research on evidence-based substance use treatments and developing clinical treatment guidelines for a range of substance use disorders. The work of the centre will help ensure that the treatment system is effective, based on the latest evidence and serviced by health professionals who are trained on the latest protocols.

In recognition that a stronger cross-government approach is required for the mental-health services across the system of care, a number of provincial ministries and service agencies will be working closely together over the next year to better link services to meet the needs of patients and families. We're taking important steps to better coordinate mental health and substance use services and break down barriers to help people connect to the services they need more quickly. This will be supported by the introduction of specialized mental health and substance use community care programs established by health authorities across B.C. These specialized community services will provide patients with a single point of contact for intake and assessment, and will ensure services are coordinated.

As a leader on the overdose crisis response, our province is also the only jurisdiction in Canada that provides diacetylmorphine and hydromorphone for opioid use disorder treatment. Providence Crosstown Clinic is the only health service delivery location that is getting practical, on-the-ground experience working with these injectable therapies.

We also recognize that chronic pain is very difficult to deal with, and that's why we support programs and services to help individuals manage it. At a Pain BC summit held earlier this month, I had the opportunity to connect with experts and professionals and offer our continued support for improving management of chronic pain and exploring the possibility of a provincial pain strategy. We have also provided more than $500,000 to Pain BC and over $2 million to Self-Management BC in 2016/17 to work with patients and their families to manage chronic pain, among other conditions.

Budget 2017 committed $165 million for a range of targeted initiatives totalling $140 million over three years to support those with mental-health and substance-use challenges, and the Province

has earmarked approximately $100 million for measures supporting the overdose crisis response since the public-health emergency was announced in April. This includes enforcement actions under the Province's Guns and Gangs Strategy, additional supports for the BC Coroners Service which includes establishment of a special investigations unit to examine illicit drug-related deaths and a public awareness campaign.

More information about our actions to combat this crisis can be found in our latest release: https://news.gov.bc.ca/releases/2017CFD0003-000369

From:	Plank, Sarah GCPE:EX
To:	Anderson, Kristy GCPE:EX; Cascaden, Lori R GCPE:EX; Forbes, Brooke GCPE:EX; Lawrie, Hannah GCPE:EX; Newton, Sarah GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject:	FW: Hydromorphone bullets for DM
Date:	Monday, February 20, 2017 11:33:02 AM

Just sharing…

From: Paton, Arlene HLTH:EX
Sent: Monday, February 20, 2017 11:29 AM
To: Brown, Stephen R HLTH:EX
Cc: Stevenson, Lynn HLTH:EX; Will, Jordan HLTH:EX; Godfrey, Debbie HLTH:EX; Plank, Sarah GCPE:EX; O'Briain, Warren W HLTH:EX; Kendall, Perry HLTH:EX
Subject: FW: Hydromorphone bullets for DM

Hi Steve – further to our discussion this morning, please see proposed bullets for the Minister below. We are going over the business case tomorrow in detail, so hope to have it finalized in the next week or so (obviously want Lynn, Manjit, Barb and others to review before finalizing).

Regards,

Arlene Paton
Assistant Deputy Minister
Population and Public Health
Ministry of Health
Phone: (250) 952-1731

From: O'Briain, Warren W HLTH:EX
Sent: Monday, February 20, 2017 11:26 AM
To: Paton, Arlene HLTH:EX; Kendall, Perry HLTH:EX
Cc: Miller, Haley HLTH:EX; Emerson, Brian P HLTH:EX
Subject: FW: Hydromorphone bullets for DM

If asked about Hydromorphone or diacetylmorphine (medical heroin) for patients who have not responded to currently available treatment modalities:

- The international evidence base for the use of diacetylmorphine to treat opioid use disorder is indisputable. Injectable diacetylmorphine is well-established in the evidence, and currently a standard of care in a number of European jurisdictions for patients who have not responded to other available treatments (about 3 to 8% of total patients on pharmacotherapy-based treatments in Switzerland, Germany, Denmark).
- Health Canada has committed to simplifying the regulatory and policy environment that surrounds the sale and supply of diacetylmorphine in Canada, but ongoing complications with the manufacturer and importation requirements means that until resolution with Health Canada regarding barriers to consistent, predictable supply is achieved, expanding opioid assisted treatment using diacetylmorphine is not an option for BC.
- However, made-in-BC research shows that for those who have failed other available treatment modalities (such as methadone and suboxone), treatment with hydromorphone generates positive outcomes that are equivalent to treatment with diacetylmorphine. (Oviedo-Joekes E, Guh D, Brissette S, Marchand K, et al., 2016)
- Therefore, the Ministry of Health is finalizing a business case that provides options for further expanding opioid assisted treatment in BC to include treatment with hydromorphone.
- Vancouver's Crosstown Clinic currently offers hydromorphone treatment to a small number of patients and is providing valuable experience and lessons that are helping inform this work.
- Using lessons learned from Crosstown Clinic and other settings, the BC Centre on Substance

Use is currently developing clinical guidelines for the provision of hydromorphone.

- Concurrently, the BC Centre on Substance Use is beginning development of advice to health authorities on how best to position hydromorphone treatment in a larger system of care.
- The Crosstown Clinic may be in a position to modestly expand the number of patients it sees before reaching physical capacity.
- Vancouver Coastal Health and other Health Authorities have a number of low barrier opioid assisted treatment approaches including those developed in response to the current public health emergency. Careful consideration on the potential role of hydromorphone in these initiatives – such as the Connections clinic that will be launched on March 1, 2017—is a next step.
- The Ministry of Health anticipates that it will provide options for hydromorphone expansion in the province to the Minister of Health for his consideration in the coming weeks.

Reference:

Oviedo-Joekes E, Guh D, Brissette S, Marchand K, et al., 2016) Hydromorphone Compared With Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. *JAMA Psychiatry*. 2016;73(5):447-455.

From:	Plank, Sarah GCPE:EX
To:	Lawrie, Hannah GCPE:EX; Forbes, Brooke GCPE:EX
Cc:	Anderson, Kristy GCPE:EX; Thistle-Walker, Carlene GCPE:EX
Subject:	FW: media stuff
Date:	Friday, January 6, 2017 9:54:27 AM

Some good stuff in here re: the case for prescription heroin/hydromorphone.

-----Original Message-----
From: D'Angelo, Anna Marie [CORP] [mailto:AnnaMarie.D'Angelo@vch.ca]
Sent: Friday, January 6, 2017 9:25 AM
To: Cascaden, Lori R GCPE:EX
Cc: Plank, Sarah GCPE:EX; Anderson, Kristy GCPE:EX
Subject: RE: media stuff

Hi Lori,
Dr. Scott will be using the standard Crosstown messaging on this .

These include the cost savings to taxpayers of such a clinic ($25K/capita/year vs. about $45K in policing, court, property damage etc costs associated with illicit drug use), the fact this is for only 10% of the substance-use population for whom other treatments haven't worked.

He'll discuss the fact it's not just a medical clinic but a holistic place that links patients to psycho-social and community supports to help get their lives on track.

He will discuss the fact there has never been a death at the clinic and how, during SALOME, of 88K injections given, there were only 14 ODs, all successfully managed - this is because it is a clinic and because the patient and doctors know exactly what is being injected.

Providence has requested the questions so hopefully they will be coming soon.

Anna Marie D'Angelo, Senior Media Relations Officer, Vancouver Coastal Health, Desk: 604.708.5340 Cell: 604.790.4763

-----Original Message-----
From: Cascaden, Lori R GCPE:EX [mailto:Lori.Cascaden@gov.bc.ca]
Sent: Friday, January 06, 2017 7:18 AM
To: D'Angelo, Anna Marie [CORP]
Cc: Plank, Sarah GCPE:EX; Anderson, Kristy GCPE:EX
Subject: RE: media stuff

Thanks so much. And, not add to your work, but I'm curious if you can share any of the responses Dr. MacDonald currently has planned, or the responses that may be developed once you see the questions?

Appreciate your help!

Lori

-----Original Message-----
From: D'Angelo, Anna Marie [CORP] [mailto:AnnaMarie.D'Angelo@vch.ca]
Sent: Friday, January 6, 2017 6:58 AM
To: Cascaden, Lori R GCPE:EX
Subject: Re: media stuff

Will do.

Anna Marie D'Angelo
From: Cascaden, Lori R GCPE:EX
Sent: Friday, January 6, 2017 6:57 AM
To: D'Angelo, Anna Marie [CORP]; Plank, Sarah GCPE:EX; Anderson, Kristy GCPE:EX; May, Stephen GCPE:EX
Cc: Adams, Clay [CORP]
Subject: RE: media stuff

Hi Anna Marie - would you be able to ask Jackie what questions she will be asking Dr. MacDonald? We would be curious to know. She is a very approachable reporter and was more than happy to share that information with us in advance.

Thank you,

Lori

From: D'Angelo, Anna Marie [CORP] [mailto:AnnaMarie.D'Angelo@vch.ca]
Sent: Thursday, January 5, 2017 11:24 AM
To: Plank, Sarah GCPE:EX; Anderson, Kristy GCPE:EX; Cascaden, Lori R GCPE:EX; May, Stephen GCPE:EX
Cc: XT:HLTH Adams, Clay
Subject: media stuff

Hi,
I spoke to the NS News this a.m. re the BCNU claim. I think it went well. I will update the IN and send to you.

St. Paul's has the following media request:
Reporter: Jackie Wong, former editor of Megaphone.
Outlet: The Tyee
What: Wants to interview Dr. MacDonald for a 3-part feature series about community solutions to the opioid crisis. Wants Dr. M's take on the impact of SALOME and OAT and what needs to happen next for OAT to become more widely accessible to pts who can benefit from it.
Interview to take place Jan. 6.

Anna Marie D'Angelo
Senior Media Relations Officer
Vancouver Coastal Health
400-520 West 6th Ave.
Vancouver, BC, V5Z 4H5
Desk: 604.708.5340
Cell: 604.790.4763
Fax: 604.874.9182
Email: annamarie.dangelo@vch.ca<mailto:annamarie.dangelo@vch.cawww.vch.ca>
www.vch.ca<http://www.vch.ca/>

From:	Emerson, Brian P HLTH:EX
To:	Lawrie, Hannah GCPE:EX
Subject:	RE: Crosstown clinic
Date:	Friday, December 2, 2016 6:20:56 PM

Hi Hannah.
The clinic expanded following the end of SALOME trial but that was not in response to the overdose epidemic, and I believe it is now closed at a maximum of 150 clients, but will confirm next week.
There is consideration of getting additional funding to expand it, as well as replicate it in other communities, which could be something to announce. That would depend on funding approval.
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

From: Lawrie, Hannah GCPE:EX
Sent: Friday, December 2, 2016 1:25 PM
To: Emerson, Brian P HLTH:EX
Subject: RE: Crosstown clinic

Thanks for the info, Brian – I'm trying to find new items to announce for Dec 15. Is the clinic now expanded?

From: Emerson, Brian P HLTH:EX
Sent: Friday, December 2, 2016 1:03 PM
To: Lawrie, Hannah GCPE:EX
Cc: Plank, Sarah GCPE:EX
Subject: RE: Crosstown clinic

And here is a Fact Sheet about the SALOME trial that led to establishment of the clinic.
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

From: Emerson, Brian P HLTH:EX
Sent: Friday, December 2, 2016 12:56 PM
To: Lawrie, Hannah GCPE:EX
Cc: Plank, Sarah GCPE:EX; Chandler, River HLTH:EX
Subject: RE: Crosstown clinic

Hi Hannah.
We do not have BN wrt Crosstown but are just starting to pull some material together (see attached).

In addition I am copying River in the Mental Health and Substance Use branch as Crosstown is a treatment program, in case they have a BN.
You can also look at their website at:
http://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

---

From: Lawrie, Hannah GCPE:EX
Sent: Friday, December 2, 2016 11:37 AM
To: Emerson, Brian P HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: Crosstown clinic

Hi Brian,

I'm pulling together materials for our update following the Coroners Service release of Nov stats on Dec 15 – will I be able to include information on the Crosstown Clinic? If so, do you have a BN or something similar I can use for background?

Thanks,

Hannah Lawrie | Sr. Public Affairs Officer
Government Communications & Public Engagement
Ministry of Health
Office 250 952-2475
Cell 250 507-1340

From:	Emerson, Brian P HLTH:EX
To:	Lawrie, Hannah GCPE:EX
Cc:	Plank, Sarah GCPE:EX
Subject:	RE: Crosstown clinic
Date:	Friday, December 2, 2016 1:03:25 PM
Attachments:	SALOME Study-Opiod Dependence Treatment - 1047056.docx

And here is a Fact Sheet about the SALOME trial that led to establishment of the clinic.
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

From: Emerson, Brian P HLTH:EX
Sent: Friday, December 2, 2016 12:56 PM
To: Lawrie, Hannah GCPE:EX
Cc: Plank, Sarah GCPE:EX; Chandler, River HLTH:EX
Subject: RE: Crosstown clinic

Hi Hannah.
We do not have BN wrt Crosstown but are just starting to pull some material together (see attached).
In addition I am copying River in the Mental Health and Substance Use branch as Crosstown is a treatment program, in case they have a BN.
You can also look at their website at:
http://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic
Thanks.
Brian

Dr. Brian P. Emerson, Medical Consultant, Population and Public Health Division
BC Ministry of Health, PO Box 9646 Stn Prov Govt, Victoria, BC V8W 9P1
T 250.952.1701 C 250.514.2219 F. 250.952. 1713 brian.emerson@gov.bc.ca

Warning: *This email is intended only for the use of the individual or organization to whom it is addressed. It may contain information that is privileged or confidential. Any distribution, disclosure, copying, or other use by anyone else is strictly prohibited. If you have received this in error, please telephone or e-mail the sender immediately and delete the message.*

From: Lawrie, Hannah GCPE:EX
Sent: Friday, December 2, 2016 11:37 AM
To: Emerson, Brian P HLTH:EX
Cc: Plank, Sarah GCPE:EX
Subject: Crosstown clinic

Hi Brian,

I'm pulling together materials for our update following the Coroners Service release of Nov stats on Dec 15 – will I be able to include information on the Crosstown Clinic? If so, do you have a BN or something similar I can use for background?

Thanks,

Hannah Lawrie | Sr. Public Affairs Officer

Government Communications & Public Engagement
Ministry of Health
Office 250 952-2475
Cell 250 507-1340

FACT SHEET

SALOME STUDY: OPIOID DEPENDENCE TREATMENT

ISSUE

Researchers from Providence Health Care/University of British Columbia are exploring alternative forms of opioid substitution treatment for people who are chronically dependent on strong opioids and do not respond to abstinence-based treatment options or pharmacotherapy such as methadone or buprenorphine/naloxone (i.e., Suboxone) maintenance. The Vancouver-based Study to Assess Longer-term Opioid Medication Effectiveness (SALOME) is testing the effectiveness of hydromorphone (i.e., Dilaudid™) as an alternative treatment in a clinical trial funded by the Canadian Institutes for Health Research.

KEY FACTS

- The purpose of this study was to determine if the closely supervised provision of injectable hydromorphone (Dilaudid™) is as effective as injectable diacetylmorphine (medical heroin) in the treatment of chronic, multi-morbid opioid-dependent individuals who have not benefited sufficiently from conventional treatments.[1]
- Findings (published in *JAMA Psychiatry* on April 6th 2016[2]) indicate that injectable hydromorphone is as safe and as effective as injectable diacetylmorphine, and most participants could not tell the difference. Treatment retention and efficacy were the same, and the risk of adverse effects was lower in the hydromorphone group.
- Neither diacetylmorphine nor hydromorphone are approved as opioid substitution treatments in Canada. The SALOME study findings support having both hydromorphone and diacetylmorphine available as clinical option for physicians to treat opioid use disorder, recognizing that both medications are likely to remain a limited option for patients who have not responded to other kinds of treatment.
- The availability of an effective, licensed opioid medication such as hydromorphone, for treatment of chronic opioid dependent treatment-refractory individuals dealing with multiple health issues, would be of immense impact locally and internationally.
- It could help to establish alternative treatment options where, for non-medical reasons, Heroin Assisted Treatment would not be acceptable, and expand treatment options for the most difficult to treat individuals with opioid use disorder.
- This would also be an important step for secondary prevention of HIV and hepatitis C as well as a better integration of those patients in other medical treatments.
- Similar studies conducted in Europe and Canada among people with chronic opioid addictions have reported that diacetylmorphine maintenance treatment improved health status, decreased use of illegal drugs, decreased criminal activity, and increased employment.
- In stage one of the SALOME study, half of the 202 participants were randomized to receive injectable heroin, and the other half received injectable Dilaudid. For the planned stage two, half the participants were continued with injection treatment exactly as in stage one, while the other half were meant to be switched to the oral equivalent of the same medication (either heroin or Dilaudid).[3] However, the stage two component was terminated for ethical reasons when clinicians observed deterioration among patients who were switch to the oral formulation (all patients ended up being provided injectable medication for the duration of the study).

---

[1] Oviedo-Joekes, E., Guh, D., Brissette, S., Marsh, D. C., Nosyk, B., Krausz, M., et al. (2010). Double-blind injectable hydromorphone versus diacetylmorphine for the treatment of opioid dependence: A pilot study. *Journal of Substance Abuse Treatment*, *38*(4), 408-411.

[2] Oviedo-Joekes, E., Guh, D., Brissette, S., Marchand, K., MacDonald, S., Lock, K., ... & Marsh, D. C. (2016). Hydromorphone Compared With Diacetylmorphine for Long-term Opioid Dependence: A Randomized Clinical Trial. JAMA psychiatry.

[3] *Study to Assess Longer0termn Opioid Medication Effectiveness (SALOME).*ClinicalTrials.gov Identifier: NCT01447212. Retrieved on February 2, 2016, from http://clinicaltrials.gov/show/NCT01447212

- Throughout the study period, social workers were assigned to both groups to assist them with additional medical and psychosocial services. At any time, participants were eligible to switch to methadone treatment, detox programs or community programs using non-pharmacological treatment modalities.
- SALOME treated patients from February 2012 until September 2014, with a total enrollment of 202 participants determined to be chronic illegal opioid users (i.e., had a history of at least five years of documented drug addiction, had not responded to other treatments and had been using heroin for at least one year immediately prior to entry into the study).[4]
- The research trial was conducted at Providence Crosstown Clinic in Vancouver.

Post-Study Access to Diacetylmorphine and Hydromorphone

- Patients who respond positively to an experimental treatment should be given the opportunity to continue treatment even if not yet approved for broader use. Article 34 of the Helsinki Declaration reads: *"…sponsors, researchers and host country governments should make provisions for post-trial access for all participants who still need an intervention identified as beneficial in the trial."*
- As per standard protocol in such situations, research physicians applied to Health Canada to secure compassionate access to the proven medication (diacetylmorphine) for exiting patients who had responded well during the trial.
- In September 2013, Health Canada approved special access to diacetylmorphine (prescription heroin) for at least 21 patients exiting the SALOME study; subsequently, federal Health Minister Rona Ambrose publicly stated her opposition to this regulatory approval and amended the Food and Drugs Act (FDA) regulations to block Canadian physicians from accessing diacetylmorphine for medical purposes.[5]
- In January 2014, five former SALOME patients and Providence Health Care launched a constitutional challenge to these FDA amendments at Supreme Court of BC.[6]
- The Minister of Justice, on behalf of the province, has joined the litigation, and Vancouver Coastal Health has been granted intervener status.
- In May 2014, Providence Health Care received an interlocutory injunction to give SALOME participants exiting the research ongoing access to diacetylmorphine. A full legal trial is expected to follow sometime in 2016.
- Providence Health Care physicians are providing patients the option of receiving either hydromorphone or diacetylmorphine following completion of the research phase of SALOME.

FINANCIAL IMPLICATIONS

CIHR provided $1.25 million for the research costs of SALOME, and Providence Health Care supported the clinical operations (approximately $1.6 million annually) until the end of the 2013/14 fiscal year. In September 2014, the Ministry and Providence Health Care entered into a Shared Cost Arrangement ($2.17 million) to cover the cost of ongoing hydromorphone and diacetylmorphine medications to provide continued care for SALOME patients following their completion of the study period until March 31, 2016.

Approved by:
Arlene Paton, ADM, Population and Public Health, Ministry of Health; May 4, 2016
Daryl Conner, Financial and Corporate Services; October 31, 2014

---

[4] Ibid.
[5] CBC News. *Rona Ambrose closing 'loopholes' in drug access program: Canadian's health minister denounces approval of heroin for B.C. medical trial.* Retrieved on February 2, 2016, from http://www.cbc.ca/news/politics/rona-ambrose-closing-loopholes-in-drug-access-program-1.1894373
[6] Providence Health Care. *SALOME: B.C. Heroin Addicts Launch Charter Challenge Against Federal Drug Ban.* (November 16, 2013). Retrieved on February 2, 2016, from http://www.providencehealthcare.org/tags/salome