| | Year | 9650 Poisoning by Opiates & Related Narcotics | T40.1 Heroin | T40.2 Opioids - includes Morphine, Codeine etc. | T40.3 Methadone | T40.4 Other Synthetic Narcotics - includes Fentanyl etc. | T40.6 Other & Unspecified Narcotics | | Total incidences of opiates contributing to death (may be combined). | Total Number of Distinct Deaths |
|---|---|---|---|---|---|---|---|---|---|---|
| ICD9 | 1989 | 20 | ---------- | ---------- | ---------- | ---------- | ---------- | | 20 | 20 |
| | 1990 | 48 | ---------- | ---------- | ---------- | ---------- | ---------- | | 48 | 48 |
| | 1991 | 91 | ---------- | ---------- | ---------- | ---------- | ---------- | | 91 | 91 |
| | 1992 | 114 | ---------- | ---------- | ---------- | ---------- | ---------- | | 114 | 114 |
| | 1993 | 258 | ---------- | ---------- | ---------- | ---------- | ---------- | | 258 | 258 |
| | 1994 | 216 | ---------- | ---------- | ---------- | ---------- | ---------- | | 216 | 216 |
| | 1995 | 122 | ---------- | ---------- | ---------- | ---------- | ---------- | | 122 | 122 |
| | 1996 | 179 | ---------- | ---------- | ---------- | ---------- | ---------- | | 179 | 179 |
| | 1997 | 156 | ---------- | ---------- | ---------- | ---------- | ---------- | | 156 | 156 |
| | 1998 | 236 | ---------- | ---------- | ---------- | ---------- | ---------- | | 236 | 236 |
| | 1999 | 152 | ---------- | ---------- | ---------- | ---------- | ---------- | | 152 | 152 |
| ICD10 | 2000 | ---------- | 110 | 103 | 33 | 16 | 9 | | 271 | 251 |
| | 2001 | ---------- | 117 | 103 | 47 | 17 | 3 | | 287 | 270 |
| | 2002 | ---------- | 67 | 105 | 53 | 17 | 1 | | 243 | 228 |
| | 2003 | ---------- | 71 | 104 | 45 | 14 | 2 | | 236 | 216 |
| | 2004 | ---------- | 63 | 123 | 51 | 6 | 3 | | 246 | 224 |
| | 2005 | ---------- | 71 | 134 | 52 | 8 | 2 | | 267 | 251 |
| | 2006 | ---------- | 82 | 123 | 48 | 11 | 4 | | 268 | 246 |
| | 2007 | ---------- | 29 | 141 | 66 | 9 | 9 | | 254 | 244 |
| | 2008 | ---------- | 35 | 156 | 59 | 13 | 16 | | 279 | 249 |
| | 2009 | ---------- | 26 | 188 | 62 | 7 | 10 | | 293 | 267 |
| | 2010 | ---------- | 62 | 161 | 82 | 10 | 17 | | 332 | 305 |
| | 2011 | ---------- | 110 | 166 | 67 | 14 | 19 | | 376 | 345 |
| | 2012 | ---------- | 101 | 158 | 92 | 27 | 11 | | 389 | 337 |
| | 2013 | ---------- | 109 | 153 | 73 | 55 | 9 | | 399 | 353 |
| | 2014 | ---------- | 119 | 137 | 58 | 93 | 6 | | 413 | 356 |
| | 2015 | ---------- | 109 | 78 | 29 | 79 | 5 | | 300 | 257 |

* Full ICD descriptions as follows:
T401 - Poisoning by and adverse effect of heroin
T402 - Poisoning by, adverse effect of and underdosing of opioids
T403 - Poisoning by, adverse effect of and underdosing of methadone
T404 - Poisoning by, adverse effect of and underdosing of other synthetic narcotics
T406 - Poisoning by, adverse effect of and underdosing of other and unspecified narcotics

Program area comment: Important to specify that:
Numbers might be impacted by the fact that cause of death is still pending on a number of registered deaths, particularly in more recent years. These deaths are being investigated by the Coroners Service and we have not yet received the Final Medical Certificate of Death
Prior to the year 2000, deaths were medically coded using ICD9 classification which did not allow for distinguishing between drug types
These numbers include both accidental and suicide overdoses
Numbers Include deaths where the drugs contributed to the death, not just deaths that were a direct result of the drugs

## Berkes, Andrea HLTH:EX

**From:** XT:Tyndall, Dr. Mark HLTH:IN
**Sent:** Thursday, March 24, 2016 10:26 AM
**To:** Kendall, Perry HLTH:EX; Lapointe, Lisa PSSG:EX
**Cc:** O'Briain, Warren W HLTH:EX; XT:Anderson, Michelle HLTH:IN
**Subject:** Re: Overdose

Keen to have this call. April 4th is possible for a call. Alternatively a face to face meeting in Victoria during the HOC meeting on the Tuesday or Wednesday could also work for me.

Mark

Dr. Mark Tyndall
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BC Centre for Disease Control

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V5Z 4R4

Phone 604-707-2405

---

**From:** , "Kendall, Perry" <perry.kendall@gov.bc.ca>
**Date:** Thursday, March 24, 2016 10:10 AM
**To:** "Lapointe, Lisa JAG:EX" <Lisa.Lapointe@gov.bc.ca>
**Cc:** Mark Tyndall <mark.tyndall@bccdc.ca>, "Warren.OBriain@gov.bc.ca" <Warren.OBriain@gov.bc.ca>, "Kendall, Perry" <perry.kendall@gov.bc.ca>
**Subject:** RE: Overdose

Thanks Lisa- that's great news.
It would be ideal if we could do Monday April 4th, as we have Health Officers Council on the Tuesday, Wednesday and Thursday and I am unavailable Friday.
I am looping Dr Mark Tyndall of BCCDC into this as BCCDC/PHSA are also co-sponsoring.
Best wishes
Perry

P. R. W. Kendall
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B.C. PUBLIC SERVICE
HALL OF EXCELLENCE MEMBER

**From:** Lapointe, Lisa JAG:EX
**Sent:** Thursday, March 24, 2016 9:28 AM
**To:** Kendall, Perry HLTH:EX
**Subject:** Re: Overdose

Hi Perry,

Thanks for your note. My office is very interested in co-sponsoring this event.

Can we arrange an initial planning meeting for the week of April 4th?

Lisa

Sent from my BlackBerry 10 smartphone on the TELUS network.

**From:** Kendall, Perry HLTH:EX
**Sent:** Thursday, March 24, 2016 9:19 AM
**To:** Lapointe, Lisa JAG:EX
**Subject:** Overdose

Hi Lisa- how did your presentation go to your executive?

I have been having follow up discussions with BCCDC/PHSA and they are interested in co-sponsoring a "Best Brains Exchange on Overdose Prevention".

Would your office be a cosponsor?

I would in any case be asking your folk to present on the data and what we know about susceptible populations, and your very proactive role on DOAP woulf fit very nicely with such an exercise.

Best wishes

Perry

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B.C. PUBLIC SERVICE
HALL OF EXCELLENCE MEMBER

## Berkes, Andrea HLTH:EX

**Subject:** FW: overdose

**From:** Daly, Patty [VC] [mailto:Patricia.Daly@vch.ca]
**Sent:** Thursday, March 10, 2016 3:54 PM
**To:** Kendall, Perry HLTH:EX; XT:Lee, Victoria HLTH:IN
**Subject:** RE: overdose

Hi Perry – Mark Lysyshyn briefed me about the meeting, and discussion of potentially declaring a provincial public health emergency, and I just spoke to Chris Buchner about it too.

My advice to Mark L. was that if the group was going to ask you do declare an emergency, you would need:

1. All the data necessary to justify a recommendation
2. List of actions recommended to respond, and who would be responsible for implementing them.

There would likely be two main reasons for declaring an emergency – to free up funds for specific actions, and/or to address any political barriers to implementation of actions.

If you remember John B.'s declaration of a public health emergency in the DTES back in the 1990's, he was asked to do so for both of the above reasons i.e. to free up significant funding from various levels of government, for the SIS and other strategies, and to address the legal barriers.

I think the question here is what new actions would be facilitated by declaring an Emergency. In terms of a symposium on the current evidence supporting prevention, harm reduction and addiction treatment, including current and new innovations – around the province these are being implemented to varying degrees, and I don't know if a symposium reviewing these would help. The barriers to broader implementation don't have to do with lack of knowledge. Mark L. didn't think a symposium would be of much benefit and Chris agrees.

In my mind the biggest barrier to making further progress is the current legal framework for psychoactive substances, which means no quality control for illicit substances – hence difficulty in stopping fentanyl contamination, which the police tell me is only going to get worse as organized crime expands into this market, given the profit margin for small amounts. To me this is the biggest unresolved barrier – we have the HOC paper – could declaring an emergency come with a call to implement a full regulatory framework, with some specific recommendations about how to do it? Maybe we could start this discussion at HOC.

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Vice-President, Public Health and
Chief Medical Health Officer
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Phone: 604-675-3924
Fax: 604-731-2756
E-mail: Patricia.Daly@vch.ca
Assistant: Mavis Chu
Phone: 604-675-3918
E-mail: Mavis.Chu@vch.ca

**From:** Kendall, Perry HLTH:EX [mailto:Perry.Kendall@gov.bc.ca]
**Sent:** Wednesday, March 09, 2016 12:19 PM
**To:** Daly, Patty [VC]; [FHA] Lee, Victoria
**Subject:** FW: overdose

Would VCH/Fraser, where most ODs are happening, be interested in co-sponsoring an event like this. I looked back at the VCH/HC Summit on Crystal Meth, which ended up informing BC and other jurisdiction's approaches.
Perry

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**From:** Kendall, Perry HLTH:EX
**Sent:** Wednesday, March 9, 2016 9:11 AM
**To:** XT:Tyndall, Dr. Mark HLTH:IN; O'Briain, Warren W HLTH:EX; Kendall, Perry HLTH:EX; Emerson, Brian P HLTH:EX
**Cc:** Henry, Bonnie HLTH:EX; Buxton, Jane CDC:IP; Kendall, Perry HLTH:EX
**Subject:** RE: overdose

Thanks Mark.
There is an opportunity to discus at the next CMOH TC. And
There is an agenda item on overdose at HOC.
As discussed yesterday we should also think about a symposium similar to the one put on by VCH to discuss crystal meth back in the early 2000's.
There's a wide gulf between where we are with our HR based recommendations for pop-up SIS's and low threshold OST or legal access to pharmaceutical alternatives to street opioids and where the broader political/law enforcement/healthcareprofessional/public etc gestalt is at.
A symposium of experts or respected reps from across the spectrum would be a good starting place I think.
Some individuals I can think of offhand include-
Jane Buxton and others from DOAP, VPD rep, RCMP rep, CMOH's, City councillors or UBCM rep, VANDU, Cdn Drug Policy Coalition, Evan Wood's network, psychiatry ? Michael Krausz, There's also a psychiatrist at UBC and Kerry Jang would be good to have on board, , Mothers of Drug Users, rep From Grief to Action, I think someone from the recovery world, College of P and S (Alvie), Coroner's office for a start.
The agenda would be to explore everything we know about the present pidemic if overdose deaths and develop a multi-themed, enhanced response for the various high-risk individuals and communities.
I like the idea of BCCDC as co-leader, I'd add in VCH and my office would be happy to assist.
Warren- any thoughts?

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B.C. PUBLIC SERVICE
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**From:** Tyndall, Mark [mailto:Mark.Tyndall@bccdc.ca]
**Sent:** Tuesday, March 8, 2016 5:31 PM
**To:** Kendall, Perry HLTH:EX
**Subject:** overdose

Hi Perry – so I would like to move forward on this quickly. There was a lot of energy and good-will in the room. I agree that convening a key stakeholder meeting prior to calling a public health emergency would be wise. If you could get a list of key people to me we would organize the call. The main messaging as it stands gives regular users few alternatives – telling them it is dangerous to use street drugs these days is not really an alternative. The things discussed included: controlled prescribed opiates (apparently Salomi trial results come out next month), pop-up supervised sites, some form of drug testing (although there are problems with relying on this); rapid access to OST; peer-based activities and intensified educational interventions; and the Good Samaritan legislation. Probably other things we can think about.

mark

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Phone 604-707-2405

**Berkes, Andrea HLTH:EX**

**Subject:** FW: overdose

**From:** Tyndall, Mark [mailto:Mark.Tyndall@bccdc.ca]
**Sent:** Wednesday, March 9, 2016 9:34 AM
**To:** Kendall, Perry HLTH:EX; O'Briain, Warren W HLTH:EX; Emerson, Brian P HLTH:EX
**Cc:** Henry, Bonnie HLTH:EX; Buxton, Jane; Hassam, Noorjean
**Subject:** Re: overdose

Thanks Perry – I understand the persistent tension between what we feel should be done and what we think could be done but it was clear to me yesterday that people are ready for a radical departure on what we are currently doing. If it was presented as an emergency response – which I believe it is – and with a strong evaluation component, I think we could do the more "innovative" interventions. The people/groups on your list are largely captured in Jane's DOAP group already so it would not be a big step to expand from this group to include the other key stakeholders. I think that we should come up with a half-day (or day) meeting date within the next 2-3 weeks and people would have to make time. The DOAP group are already expecting to meet again soon following a decision that there needs to be renewed and urgent attention to the issue – like a Public Health Emergency announcement. I will discuss this with Jane today and we can come up with a date and begin to organize this.

mark

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---

**From:** <Kendall>, "Kendall, Perry" <perry.kendall@gov.bc.ca>
**Date:** Wednesday, March 9, 2016 9:10 AM
**To:** Mark Tyndall <mark.tyndall@bccdc.ca>, "Warren.OBriain@gov.bc.ca" <Warren.OBriain@gov.bc.ca>, "Kendall, Perry" <perry.kendall@gov.bc.ca>, "Emerson, Brian" <Brian.Emerson@gov.bc.ca>
**Cc:** "Henry, Bonnie" <bonnie.henry@gov.bc.ca>, "Buxton, Jane" <Jane.Buxton@bccdc.ca>, "Kendall, Perry" <perry.kendall@gov.bc.ca>
**Subject:** RE: overdose

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Some individuals I can think of offhand include-
Jane Buxton and others from DOAP, VPD rep, RCMP rep, CMOH's, City councillors or UBCM rep, VANDU, Cdn Drug Policy Coalition, Evan Wood's network, psychiatry ? Michael Krausz, There's also a psychiatrist at UBC and Kerry Jang would be good to have on board, , Mothers of Drug Users, rep From Grief to Action, I think someone from the recovery world, College of P and S (Alvie), Coroner's office for a start.
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I like the idea of BCCDC as co-leader, I'd add in VCH and my office would be happy to assist.
Warren- any thoughts?

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**B.C. PUBLIC SERVICE**
**HALL OF EXCELLENCE MEMBER**

---

**From:** Tyndall, Mark [mailto:Mark.Tyndall@bccdc.ca]
**Sent:** Tuesday, March 8, 2016 5:31 PM
**To:** Kendall, Perry HLTH:EX
**Subject:** overdose

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This is a provincial issue and BCCDC should take a leadership role in partnership with the PHO/Ministry.

mark

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Executive Medical Director
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655 West 12th Ave
Vancouver, BC

**Berkes, Andrea HLTH:EX**

**Subject:** FW: overdose

**From:** Lapointe, Lisa JAG:EX
**Sent:** Wednesday, March 9, 2016 9:47 AM
**To:** Kendall, Perry HLTH:EX
**Subject:** RE: overdose

Thanks Perry.

It was good speaking with you. I look forward to touching base again once we've had opportunities to further discuss potential strategies with our respective colleagues.

For your consideration, given that the focus of the proposed symposium is on deaths, and a significant portion of the data is derived from BCCS investigations, I suggest that the Office of the Chief Coroner would also be a logical co-leader. One of the key mandates of our work is preventing future deaths in similar circumstances, and a leadership role for BCCS on this issue would highlight the gravity of the current situation while fitting logically with our responsibilities.

Talk to you soon,
Lisa

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**From:** Kendall, Perry HLTH:EX
**Sent:** Wednesday, March 9, 2016 9:17 AM
**To:** Lapointe, Lisa JAG:EX
**Subject:** FW: overdose

fyi

P. R. W. Kendall
OBC, MBBS, MHSc, FRCPC
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**Sent:** Wednesday, March 9, 2016 9:11 AM
**To:** XT:Tyndall, Dr. Mark HLTH:IN; O'Briain, Warren W HLTH:EX; Kendall, Perry HLTH:EX; Emerson, Brian P HLTH:EX
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B.C. PUBLIC SERVICE
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This is a provincial issue and BCCDC should take a leadership role in partnership with the PHO/Ministry.

mark

Dr. Mark Tyndall

**Berkes, Andrea HLTH:EX**

**Subject:** FW: Overdose death DOAP update FYI

**From:** Tyndall, Mark [mailto:Mark.Tyndall@bccdc.ca]
**Sent:** Thursday, February 25, 2016 11:30 AM
**To:** Emerson, Brian P HLTH:EX
**Cc:** Henry, Bonnie HLTH:EX; Buxton, Jane; O'Briain, Warren W HLTH:EX; Tupper, Kenneth HLTH:EX; Perkin, Kathleen M HLTH:EX; Kendall, Perry HLTH:EX
**Subject:** Re: Overdose death DOAP update FYI

Thanks Brain – and Jane for all of your work on this. I do not think that increasing access to naloxone or enhanced awareness programs (obviously important) are going to have much impact on these rates - if they go down it is because many of the most susceptible people will have died. The spike is driven primarily through enhanced prohibition which is acting on several fronts – the discontinuation of oxy–contin in 2012 which was a main pharmaceutical-grade "illicit" street-based substitute for heroin; high profile blame of physicians who prescribe opiates and subsequently have stopped doing it; continued scale-up on the supply side which has resulted in the import of more concentrated ingredients resulting in these high-concentreated fentanyl based pills and powder that have flooded the market. So I would support Brian's comments on finding a way to provide people some access to pharmaceutical grade opiates. I know that some physicians are doing this already but it is certainly frowned upon and few patients can take advantage of this. Putting back Oxy-contin would likely have an immediate impact – a sort of failed experiment in prohibition. Although the impact is being felt in a range of population groups, the majority are still happening in the most entrenched and marginalized people who would access harm reduction services and this would be a built-in network to initiate these interventions. This is indeed a public health crisis that is being played out across Canada. BC could really take a lead in this.

mark

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**From:** <Emerson>, Brian <Brian.Emerson@gov.bc.ca>
**Date:** Thursday, February 25, 2016 10:42 AM
**To:** "Kendall, Perry" <perry.kendall@gov.bc.ca>
**Cc:** "Henry, Bonnie" <bonnie.henry@gov.bc.ca>, Mark Tyndall <mark.tyndall@bccdc.ca>, "Buxton, Jane" <Jane.Buxton@bccdc.ca>, "Warren.OBriain@gov.bc.ca" <Warren.OBriain@gov.bc.ca>, "kenneth.tupper@gov.bc.ca" <kenneth.tupper@gov.bc.ca>, "Perkin, Kathleen M HLTH:EX" <Kathleen.Perkin@gov.bc.ca>
**Subject:** Overdose death DOAP update FYI

FYI and - see below. The police summary "Fentanyl Update from RCMP" at the website is interesting – see www.towardtheheart.com/doap (password: s.15 )

This is very depressing. As discussed, perhaps we need to start thinking about more aggressive and definitive interventions. Given the mounting death toll perhaps a case could be made for getting a section 56 exemption for BC to make pharmaceutical grade opioids available through harm reduction sites. It is clear that people are going to use opioids irrespective of the risk so giving them small quantities of something of known concentration through a service that can provide them with advice on safer use, and provide them with an overdose kit, is something worth consideration. And we do know that connecting with harm reduction services has other health promoting benefits. Would be interested in your thoughts on this idea.

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:** Buxton, Jane [mailto:Jane.Buxton@bccdc.ca]
**Sent:** Thursday, February 25, 2016 8:54 AM
**To:** _BCCDC_OD
**Subject:** DOAP update FYI

Dear all,

The latest Coroners illicit drug report (for Jan 2016) is posted on the DOA website. As are the minutes from our last meeting Feb 4th
As always the latest report is not for public sharing; it unfortunately indicates the apparent deaths for 2015 are now the highest number **and highest rate** ever reported and January 2016 is continuing the trend. The latest fentanyl report is also posted under side bar BC Corners Service.

The Opioid Overdose Strategy was released on Feb 15th : http://www.bccdc.ca/about/news-stories/news-releases/2016/recommendations-for-an-opioid-overdose-strategy-in-bc

We continue to see numerous alerts in the ambulance data call data every week

Naloxone is becoming more accessible -Health Canada is receiving public input about making naloxone non-prescription, BC Emergency Health Services in BC has developed a process for firefighters to carry and administer Nx once a collaborative agreement and training has occurred and Vancouver and Fraser are rolling out a delegated program on Nx in some shelters

See you at our next meeting March 8 3-4:30pm when we are discussing what else we should be doing e.g. schools, public fora etc.

Warm regards

Jane

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Fax: 604-707-2441
www.bccdc.ca

# BC DOAP Opioid Overdose Response Strategy (DOORS)

## Background

Since 2010, accidental illicit drug overdose deaths have continued to increase at the regional, provincial and national levels. In 2015, there were 465 deaths apparent illicit drug overdoses in BC, a 27% increase from 366 deaths in 2014 and the highest number of illicit drug overdose deaths (IDD) since 1998.[i] Although most IDD are due to the consumption of multiple substances, preliminary data from the BC Coroners Service show that the proportion of IDD where fentanyl is detected (alone or in combination with other drugs) has increased from less than 5% in 2012 to approximately 30% in 2015.

**The annual mortality rate due to illicit drug overdose in BC has risen from 4.7 per 100,000 in 2010 to 9.9 per 100,000 in 2015.** This 100% increase in the mortality rate is troubling, given the increasing expansion of access to harm reduction services including overdose prevention training and take home naloxone. In comparison, the motor vehicle fatality rate in BC in 2012 was 6.2 per 100,000, the rate of deaths due to HIV disease in BC from 1996-2011 was 3.03 per 100,000, and the rate of accidental deaths related to prescription opioids in BC from 2005-2010 was 1.1 per 100,000.[ii,iii]

Death, severe brain damage and other harms due to oxygen deprivation during an opioid overdose have been shown to be reduced through overdose education, supervised consumption facilities,[iv] and community-based naloxone[1] programs.[v,vi] Naloxone programs have been operational in the US and Europe since the late 1990s; Canada's first program began in 2005 and the British Columbia Take Home Naloxone program started in 2012.

## Key Immediate Recommendations for Action

In response to this public health crisis, the BC Drug Overdose and Alert Partnership (DOAP) members have identified a number of key actions that municipal, provincial and federal agencies can take to help address this crisis:

### 1. Increase Access to Naloxone, an Opioid Overdose Antidote, Through Changes in Practice

- Health authorities should expand the BC Take Home Naloxone (THN) program sites for at-risk groups and the general public:
  - In community health centres, First Nations health centres and community-based agencies
  - In acute care settings including emergency departments (EDs) *(currently 8 ED sites in BC[2])*
  - In substance use withdrawal management and treatment facilities (including Opioid Substitution Treatment clinics)
- Provincial and federal correctional facilities should expand access to THN programs on release *(currently a pilot in 2 provincial institutions in BC)*
- Provide access to naloxone for non-medical staff working in community settings where overdoses occur (e.g. in shelters, temporary housing, drop-in centres, etc.)
- Healthcare professionals' colleges and associations should encourage physicians, nurse practitioners and nurses to prescribe and/or dispense naloxone including as a co-prescription to people who are receiving opioids and may be at risk for an overdose

[1] Naloxone is an opioid antagonist which can quickly restores breathing during an opioid overdose
[2] Enrolled in BC Take Home Naloxone program as of February 3, 2015

## 2. Increase Access to Naloxone Through Changes in Policy

- Health Canada should change naloxone to a non-prescription medication to increase access to naloxone for the public, family and friends of people at risk of overdose and non-medical staff working in community settings where overdoses occur
- College of Pharmacists of BC and the BC government should act quickly to change drug scheduling, to provide the least barriers to access naloxone while ensuring proper consumer education, when there are changes in federal scheduling or changes in available formulations
- BC Ministry of Health should expedite providing coverage for naloxone under BC's PharmaCare
- Municipal fire departments should sign consent agreements with BC Emergency Health Services to allow their firefighters to receive training and approval to administer naloxone when responding to an overdose-related call
- Law enforcement agencies should review current policies to ensure the best and most rapid medical response to an opioid overdose.
- Encourage pharmaceutical manufacturers to submit applications for the use of intranasal (IN) naloxone to Health Canada (IN administration is more acceptable to responders who do not inject drugs and is used by many US law enforcement agencies)
- Health Canada should expedite the approval process for any naloxone-related applications

## 3. Improve Overdose Prevention Education, Training and Services

Health care and allied health professionals as well as provincial and regional organizations with mandates to promote public health and safety should work together to:

- Provide training for staff to have trauma-informed[3] discussions with individuals with known current or recent substance use problems about how to prevent, recognize and respond to overdoses
- Encourage health care and social service providers to work from a trauma-informed[vii] lens to strengthen client-provider relationship and foster open dialogues around substance use
- Increase physician awareness of best practices for opioid prescribing and encourage physicians to carefully review patients' medical and medication histories and consider relationship with the patient when prescribing opioids.[viii] For example:
    - Opioid-naïve patients (i.e. who have not been prescribed opioids before) should be prescribed a lower dose or a short course of opioids
    - Avoid co-prescribing opioids with benzodiazepines or other sedating medications
    - Patients receiving continuous/ongoing prescriptions of opioids should not have their prescriptions suddenly stopped or have their dose of prescription opioids abruptly reduced as this may result in patients managing withdrawal and pain symptoms through illicit means. Suspicions of diverted medications or addiction should be confirmed through a candid conversation with the patient, random pill counts/urine drug testing and daily dispensing/witnessed ingestion. Options for withdrawal management and opioid substitution treatment should be discussed with the patient.

[3] Trauma is defined as "experiences that overwhelm an individual's capacity to cope". Trauma informed services work at the client, staff, agency, and system levels from the core principles of: trauma awareness; safety; trustworthiness; choice and collaboration; and building of skills and strengths. Additional details can be found in the Trauma Informed Practice Guide endorsed by the BC Ministry of Health and the BC Mental Health Substance Use Services.

- Establish a professional practice standard requiring the prescriber to review PharmaNet before prescribing opioids (or benzodiazepines and stimulant) medications
- Inform/train staff on overdose prevention, recognition and response strategies
- Provide training to laypersons, patients and their social network that is trauma-informed and teaches them how to recognize and respond to overdoses
- Raise awareness about overdose symptoms and response in different affected populations by placing relevant messages in:
    - Areas with high visibility (public transit vehicles & shelters)
    - Areas where people are likely to use drugs (public washrooms, clubs, etc.)
    - Targeted outreach to at-risk groups
- Provide evidence-informed, fact-based education to younger adults about overdose prevention, recognition and response (including calling 911 immediately) through schools and post-secondary institutions
- Include overdose prevention, recognition and response training as part of standard first aid training
- Require BC Housing and all Health Authorities who contract with supportive housing non-profits to have an opioid overdose policy including, but not limited to naloxone.
- Expand access to supervised consumption services in regions of BC where overdose deaths are a public health concern[iv]
- Work with the federal government to facilitate approvals for new supervised consumption services in BC
- Expand access to evidence-based withdrawal management and substance use support services, including opioid substitution therapy which reduces opioid overdose risk by almost 90%[ix]

## 4. Enhance Surveillance and Utilization of Overdose Data

Provincial and regional organizations with mandates to promote public health and safety should take leadership and provide resources to:

- Increase the timely collection, analysis, and dissemination of data on drug overdose events in collaboration with regional and provincial partners
- Improve data sharing between law enforcement, public health, researchers, coroners service, drug analysis and toxicology labs to improve response plans and early warning to reduce harms
- Improve the format of surveillance and alert data disseminated to the partners
- Review the evidence for making overdoses a reportable condition to allow follow-up by public health agencies and improve the quality of data collected
- Support increased communication about unexpected/unusual drug-related events within and between government agencies and with the general public
- Conduct a review of overdose deaths to inform recommendations to prevent and reduce harms
- Develop system for community-level reporting of unexpected/unusual drug-related events as an early warning system e.g. developing an online tool
- Improve access to drug checking (testing) capacity in communities to increase accuracy of real-time surveillance as issues arise

**About Us:**

The BC Drug Overdose and Alert Partnership (DOAP) is a multi-sectoral committee that was established to prevent and reduce the harms associated with substance use. The group identifies and disseminates timely information about harms related to substance use including overdose, adverse reactions to contaminated products, and other emerging issues. DOAP is chaired by the Harm Reduction Lead at the BC Centre for Disease Control. Member agencies include:

- Provincial Health Service Authority agencies:
  - BC Centre for Disease Control
  - BC Emergency Health Services
  - BC Drug and Poison Information Centre
  - BC Provincial Toxicology Centre
- BC Centre for Excellence HIV/AIDS - Urban Health Research Institute
- BC Coroners Service
- BC Regional Health Authorities
  - Fraser Health
  - Interior Health
  - Northern Health
  - Vancouver Coastal Health
  - Island Health
- BC Ministry of Health
- Centre for Addictions Research of BC, University of Victoria
- First Nations Health Authority
- Health Canada Drug Analysis Service
- Various law enforcement agencies in BC
- Vancouver Area Network of Drug Users

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