MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

Cliff # 1096870

PREPARED FOR: Honourable Judy Darcy - **FOR INFORMATION**

TITLE: Low Barrier Oral Hydromorphone to Prevent Fatal Overdoses: BC Centre for Disease Control proposal to the Health Canada Substance Use and Addictions Program

PURPOSE: To inform Minister Darcy about proposal for low barrier oral hydromorphone program being submitted to Health Canada

BACKGROUND:
On April 14, 2016, a public health emergency was declared in British Columbia (BC) in response to the epidemic of opioid overdose deaths. In 2016, 967 people in BC died from overdose due to fentanyl contaminating the illegal drug supply, and evidence suggests we are on track to exceed this death toll in 2017[i]. Urgent action is required to prevent overdose deaths of individuals at risk of overdose. The BC Overdose Action Exchange 2016/2017 report and Vancouver Police Department 2017 report recommended immediate widespread distribution of effective opioid substitution drugs and increased access to a safer drug supply[ii,iii].

In their proposal to the Health Canada Substance Use and Addictions Program (Appendix B), a multi-agency, two province team led by Dr. Mark Tyndall of the BC Centre for Disease Control proposes a low barrier, scalable model of oral hydromorphone distribution to rapidly expand access to pharmaceutical-grade opioids as an alternative to the toxic drug supply responsible for the epidemic of opioid overdose deaths in BC and Alberta.

The proposed project will develop strategies to reach individuals using opioids from the illegal supply, particularly those using alone, as well as those not connected to community or engaged with health services.

Oral hydromorphone tablets proposed for use in the project are inexpensive and easily accessible. Hydromorphone would be prescribed by a physician or registered nurse through delegated authority, dispensed by a community pharmacist, delivered, documented, audited, and stored according to Health Canada and provincial regulations for controlled substances.

Development of the project will include ethics review, consultation with professional Colleges, addictions physicians, health authorities, medical associations, and public safety representatives and peer networks.

DISCUSSION:
Current uses of hydromorphone (HDM) tablets are limited to pain management so the proposed low-barrier harm reduction model falls outside current use indications for oral HDM tablets and will be considered "off-label", which may raise concerns from regulatory bodies. In addition, there may be policy implications with respect to requirements of the federal *Controlled Drugs and Substances Act and Narcotic Control Regulations*, and provincial *Pharmacy Operations and Drug Scheduling Act*. The proposal has built in plans to engage with the relevant regulatory bodies to work through any potential policy implications.

The research will address such questions as to the provision of tablets (containing other components in addition to the drug) for crushing and injecting, rather than using powdered HDM and the use of the most appropriate substance.

The research will also help identify the physician and pharmacy costs as well as daily dose of HDM required by most clients.

Dr. Tindal has expressed an interest to work within the new Overdose Emergency Response Centre structure to undertake this research project. A meeting is being set up in January to have further discussions.

ADVICE:
Continue to engage with Dr. Mark Tyndall and his team to discuss the policy implications of the proposed project.

Program ADM/Division:
Telephone: (250) 952 1003
Program Contact (for content): Carolyn Davison, A/ED, Ministry of Mental Health and Addictions
Drafter: Mikhail Torban, Brian Emerson
Date: December 18, 2017

Appendix A - References

[i] BC Coroners Service (2017) Illicit Drug Overdose Deaths in BC January 1, 2007 - July 31, 2017. Retrieved on October 26, 2017 from http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

[ii] BC Centre for Disease Control (2017) BC Overdose Action Exchange II. Meeting report. Retrieved on October 26, 2017 from http://www.bccdc.ca/resource-gallery/Documents/bccdc-overdose-action-screen.pdf

[iii] Vancouver Police Department (2017) The Opioid Crisis: The Need for Treatment on Demand. Review and recommendations, May 2017. Retrieved on October 26, 2017 from http://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf

Health Canada Santé Canada

Substance Use and Addictions Program (SUAP)

FULL PROPOSAL TEMPLATE

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MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

Cliff # 1097125

PREPARED FOR: Honourable Judy Darcy, Minister of Mental Health and Addictions
- FOR INFORMATION

TITLE: Vancouver Coastal Health Assistance to the Overdose Prevention

PURPOSE: To provide the Minister with information on how Vancouver Coastal Health has responded to concerns raised by a peer-based overdose prevention service location in Vancouver

BACKGROUND:
BC remains in the midst of an epidemic of illegal drug overdoses and overdose deaths. In December 2016, spikes in 9-1-1 calls for overdose response and continued overdose deaths prompted the Health Minister to sign a ministerial order under the *Emergency Health Services Act* and *Health Authorities Act* to activate overdose prevention services (OPS) throughout the province.

OPS sites vary considerably in structure and function; some are new sites and others are enhancements to existing harm reduction and outreach services. In contrast to the full suite of services provided by permanent supervised consumption services, these overdose prevention services are temporary and provide a safe space for people who use drugs to be monitored in case of overdose.

As of November 30, 2017, there are 26 overdose prevention service locations throughout the province; these locations have had over 532,000 visits and have aided in the reversal of over 2,400 overdoses. To date, no one has died of an illegal drug overdose at any overdose prevention or supervised consumption location in BC.

Since 2016, the Overdose Prevention Society has coordinated the operation of an OPS on 62 East Hastings Street in Vancouver between 10 am and 10 pm daily. This peer-based service spearheaded by Sarah Blyth was originally established as a pop-up tent, before converting into a modified first aid trailer in December 2016. It is estimated that the OPS has seen over 100,000 visits and has reversed 300 overdoses since its establishment.

DISCUSSION:
In a letter to the Minister of Mental Health and Addictions (see Appendix A), MLA Sonia Furstenau (Cowichan Valley) noted the Overdose Prevention Society raised concerns to her around meeting basic needs for operating the OPS during the winter weather. MLA Furstenau has asked what the Ministry of Mental Health and Addictions is doing to help the Overdose Prevention Society prepare for the winter months, and offered her assistance. Sarah Blyth also reached out to BC Housing, the City of Vancouver, and Vancouver Coastal Health to request assistance.

In response to Sarah's request, BC Housing, the City of Vancouver, and Vancouver Coastal Health secured a permanent indoor location for the OPS situated next door to where the trailer had been operating. The indoor location opened on December 20, 2017.

ADVICE:
In response to a request for assistance, BC Housing, the City of Vancouver, and Vancouver Coastal Health secured a permanent indoor space for the Overdose Prevention Society to continue operating its OPS. A letter of congratulations from A/Executive Director, Carolyn Davison, has been sent to Sarah Blyth celebrating the opening of the indoor services. The Minister may wish to consider responding to MLA Furstenau noting this news.

Program ADM/Division: Taryn Walsh
Telephone:
Program Contact (for content): Carolyn Davison
Drafter: Haley Miller
Date: December 29, 2017

LEGISLATIVE ASSEMBLY
of BRITISH COLUMBIA

Sonia Furstenau MLA
Cowichan Valley

Hon. Judy Darcy
Ministry of Mental Health and Addictions
Parliament Buildings, Room 346
Victoria, BC
V8V 1X4

Dear Minister Darcy,

I have been in contact with members of the Overdose Prevention Society about their concerns for the upcoming winter. There are a number of basic necessities they will need to continue their live-saving work as the weather worsens.

They listed:

- Heaters;
- Hydro;
- Water, plumbing;
- A long term lease;
- Internet;
- A better outdoor roof;
- Security cameras;
- An outdoor wash stand.

They also spoke about needing the ability to give out safe clean drugs on site and hope to move into the indoor space next to their 62 East Hastings St. location.

Starting with their initial basic needs, I would welcome the opportunity to discuss what your ministry is doing to help them prepare for the winter and how I can best be supportive of these efforts.

Many thanks,

Sonia Furstenau,
MLA Cowichan Valley

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MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

CLIFF #: 1101770

PREPARED FOR: Honourable Judy Darcy, Minister - **FOR INFORMATION**

TITLE: BC's Policy Change from Pharmacy-Compounded Methadone to Commercially Prepared Formulation (Methadose) for Opioid Use Disorder

PURPOSE: To provide the Minister with information on the 2014 policy change from a compounded version of methadone to a commercially prepared version of methadone for the treatment of opioid use disorder.

BACKGROUND:

Opioid substitution therapy is a highly effective treatment for opioid use disorder. In BC, PharmaCare covers methadone, buprenorphine/naloxone, and slow-release oral morphine for opioid use disorder treatment under Plan G, and covers injectable hydromorphone for a small number of eligible patients.

If a commercially prepared formulation of a pharmacy-compounded medication is available, it is Health Canada's policy that provinces and territories dispense the commercial product to avoid errors at the pharmacy level. In 2014, a commercially prepared formulation of methadone, Methadose, was approved for use in Canada. All provinces and territories switched to Methadose to reduce compounding errors and to reduce risk of diversion; BC implemented this switch effective February 1, 2014.

Preparation for the product switch took the better part of a year as considerable work needed to occur, including:

- The College of Pharmacists of BC established the standard concentration of methadone as 10 mg/mL
- The College of Pharmacists of BC established a bylaw that prevents the dispensing of a previous formulation of methadone (i.e. compounded methadone)
- PharmaCare approved policy to only cover Methadose (and no longer compounded methadone) to avoid potential dispensing errors
- Provider training (including pharmacists and physicians)
- Education for public and patients on the change in concentration, flavor, and amount of methadone dispensed [1]

DISCUSSION:

In 2014, the BC Ministry of Health began receiving informal complaints from patients that suggested that Methadose was not sufficient for a number of individuals. No formal requests from physicians to cover compounded methadone were received by the Ministry of Health, and while complaints from patients eventually subsided, anecdotal reports that Methadose was not working for some people continued. Addictions specialist

[1] https://news.gov.bc.ca/releases/2014HLTH0002-000020

Dr. Keith Ahamad from the BC Centre on Substance Use reports that he has had several patients describe poor response to Methadose after the policy change.

Studies on the impact of BC's policy change have highlighted increases in illegal heroin usage and decreases in adherence to HIV treatment among those living with HIV[2], the need for patients to increase the methadone dose and an increase in withdrawal and pain symptoms[3], and other pronounced negative effects among those who are structurally vulnerable[4].

The BC Centre on Substance Use (BCCSU), responsible for managing BC's opioid substitution therapy program, has released guidelines on the treatment of opioid use disorder noting that buprenorphine/naloxone is now recommended as first-line treatment for opioid dependence. The BCCSU notes that there is not enough research on patients on Methadose switching to buprenorphine/naloxone to recommend this change, but a clinical trial to learn more about how patients would fare is being considered.

Laura Shaver, President of the BC Association of People on Methadone, has written to the Ministry of Health and previous government about the switch to Methadose, and has since written to Minister Darcy in November 2017 (see Appendix A) reporting that Methadose does not last as long as the compounded formulation for herself and others. Ms. Shaver notes that some patients – herself included – have relapsed into illegal drug use due to the policy change, and that some of these individuals have experienced non-fatal or fatal overdoses. The letter requests a meeting with the Minister, and asks that government provide compounded methadone to individuals who find Methadose inadequate.

ADVICE:
The escalation of the province's response to the overdose crisis supports the general principle of having all opioid substitution therapy options available and to tailor treatment to individual needs. Individuals who report feeling forced to seek out illegal drugs in the absence of appropriate treatment are at a high risk of preventable overdose and overdose death. In addition, studies have demonstrated that the policy change to dispense only commercially formulated methadone has resulted in negative impacts to those who are already structurally vulnerable.

In this context, Ministry staff and the Overdose Emergency Response Centre support the Minister in considering a recommendation to the Ministry of Health to provide pharmacy-compounded methadone to patients who report that Methadose is inadequate.

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[2] Socías, M. Eugenia, et al. "Unintended impacts of regulatory changes to British Columbia Methadone Maintenance Program on addiction and HIV-Related outcomes: An interrupted time series analysis." *International Journal of Drug Policy*, vol. 45, 2017, pp. 1–8., doi:10.1016/j.drugpo.2017.03.008.
[3] Mcneil, R., Kerr, T., Anderson, S., Maher, L., Keewatin, C., Milloy, M., . . . Small, W. (2015). Negotiating structural vulnerability following regulatory changes to a provincial methadone program in vancouver, canada: A qualitative study. Social Science & Medicine, 133, 168-176. doi:10.1016/j.socscimed.2015.04.008
[4] Greer, A. M., Hu, S., Amlani, A., Moreheart, S., Sampson, O., & Buxton, J. A. (2016). Patient perspectives of methadone formulation change in British Columbia, Canada: outcomes of a provincial survey. Substance Abuse Treatment, Prevention, and Policy, 11(1). doi:10.1186/s13011-016-0048-3

Similar to the policy change in 2014, reversing this policy change would be a lengthy process. To allow for the provision of compounded methadone, Ministry of Health staff have advised that considerable work would need to be undertaken, including:

- The College of Pharmacists of BC would need to amend their bylaw to allow for a compounded formulation to be dispensed when a commercial formulation exists
- The College of Pharmacists of BC would need to amend their bylaw to allow for a concentration other than 10 mg/ml of methadone to be dispensed in BC.
- A prescribing physician would need to request Special Authority approval and provide a detailed reason why a patient needs to be on compounded methadone in order for PharmaCare to cover the medication – or – to reduce the barriers associated with PharmaCare would need to make a policy change to cover this medication under Plan G (either would involve substantial work on the part of providers and the Ministry of Health)
- Additional training for care providers and others on compounded methadone
- Clear messaging to providers, patients and the public would need to occur, including communicating the risk of having multiple strengths of methadone available in the market as patients may accidentally overdose
- The Ministry of Health would be in contravention of a nationally adopted policy to dispense commercially formulated medication over compounded medication
- Forecasting for cost pressures to the PharmaCare budget due to increases in pharmacy-level costs for compounding, witnessing and dispensing compounded methadone

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Program ADM/Division: Taryn Walsh, Assistant Deputy Minister
Telephone: 604-760-1277
Program Contact (for content): Carolyn Davison
Drafter: Haley Miller
Date: January 24, 2018

From: **Laura Shaver** <shaverlaura4@gmail.com>
Date: Fri, Nov 10, 2017 at 11:20 AM
Subject: Meeting request
To: MH.Minister@gov.bc.ca

November 10th 2017

Minister Darcy
Ministry of Mental Health and Addictions
PO BOX 9087
STN PROV GOVT Victoria, BC
V8W 9E4
SUBJECT: Meeting Request with Minister

The BC Association of People on Methadone congratulates you recent your appointment and the founding of this new ministry.

In your speech at the Recovery Capital Conference earlier this month, you said the overdose crisis "has been building for years.' We agree.

Some decisions of the previous government helped set the stage for the current crisis. In 2014 they switched all 17,000 methadone patients to a new formulation called Methadose. We warned them this was a risky move. For half of us, it never worked. Suddenly, we were dope sick after only 14 or 16 hours.

Dr. Ryan McNeil, Research Scientist with the BC Centre on Substance Use, has studied the the change from methadone to Methadose, looking at hundreds of patients. He found that for half of us it does not last long enough.
I had ceased using heroin for several years - until the switch. Methadose doesn't work for me. It doesn't have "legs." Many in our group and in our community relapsed after the introduction of Methadose, returning to the use of street drugs to top up. Many of us have overdosed. Some of our members and directors have died from this. The switch was so destabilizing, our group almost didn't survive.

We would like to meet with you to detail this situation and request that we have the option of having the old formulation dispensed to us.

Our group has been around for more than a decade. We are part of the Vancouver Area Network of Drug Users, which is now in its 20th year. We are all survivors. None of us are paid a wage for this work. We all have lived this story. Collectively, we have reversed hundreds of overdoses. Collectively we have lost hundreds of friends.

We'd like to meet with you and your senior staff at your earliest convenience. We look forward to hearing from you so we open a dialogue develop a more positive relationship with you and your new ministry that we had with your predecessors.

Sincerely

Laura Shaver President,BC Association of People on Methadone

Shaverlaura4@gmail.com

phone 604-683-6061
cell 778-939-7192

MINISTRY OF HEALTH /
MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

Cliff # 1108311

PREPARED FOR: Honourable Judy Darcy, Minister, Mental Health and Addictions
- FOR INFORMATION

TITLE: WorkSafeBC

PURPOSE: To provide an overview of WorkSafeBC's (WSBC) efforts to address the overdose emergency and pain management programs and services

BACKGROUND:

- In 2016, nearly 150,000 BC workers were injured on the job with an associated compensation cost of $1.09 billion.[1] The majority (62%) were men with an average age of 42; young workers (aged 15-24) made up 13 percent of workplace injuries, and older workers (aged 55+) made up 21 percent.[2] Workers in the construction and trade sectors had a higher rate of injury and serious injury than other BC workers.[3]
- Workers living with pain are contributing to the Opioid Overdose Public Health Emergency. An analysis of 90 recent serious but non-fatal overdoses among men living in residential areas of Fraser Health found, when current or past industry was noted, the most common industry they worked in was the building trades.[4] Additionally, half identify physical trauma or pain as a major stressor, and nearly 75% had a diagnosed alcohol or other substance use disorder and half had previously participated in substance use treatment.
- People commonly use substances to self-medicate pain, anxiety, and depression. One in five British Columbians is living with chronic pain[5]; similarly, over the course of a year, one in five British Columbians will experience significant mental health and/or substance use problems.[6]
- It is suggested as many as 60 percent of people with an opioid use disorder live with chronic pain.[7] Many people with chronic pain struggle with mental health problems due to their pain condition: people with chronic pain are four times as likely to experience depression or anxiety, and twice as likely to die by suicide as the general population[8].

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[1] https://www.worksafebc.com/en/resources/about-us/annual-report-statistics/2016-stats?lang=en
[2] Ibid.
[3] https://online.worksafebc.com/anonymous/wcb.ISR.web/IndustryStatsPortal.aspx?c=6
[4] http://www.fraserhealth.ca/media/20180122_Hidden_Epidemic_FH_CMHO_2017_Report(1).pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298051/
[6] Ministry of Health. 2010. Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in BC.
[7] https://store.samhsa.gov/shin/content/SMA12-4671/TIP54.pdf
[8] http://www.chronicpaintoronto.com/wp-content/uploads/2016/06/pain_fact_sheet_en.pdf

- Health care providers in BC have reported difficulty in meeting the complex care needs of these patients in the absence of education, training, and availability of publically-funded treatment options. Opioids are commonly prescribed to treat chronic pain, but their long-term use is controversial,[9] and increasingly restricted. Evidence indicates that alternative therapies (e.g., massage, physiotherapy, mindfulness, cognitive behavioural therapy) are effective in treating chronic pain, but access to these services are limited, and not publicly funded in BC.

DISCUSSION:

- At a meeting on December 7, 2017, between WSBC and staff from Ministry of Health (MOH) and Ministry of Mental Health and Addictions (MMHA), WSBC presented an overview of opioid harm reduction activites at WSBC from 2010 to 2017. At a subsequent meeting on January 10, 2018, WSBC provided an overview of their pain and addiction programs. A third meeting to take place in March will focus on WSBCs education program for health care providers, and potential opportunities to increase chronic pain management education supports for BC health care providers.
- The primary WSBC program for injured workers requiring treatment for ongoing pain is the Pain and Medication Management Program (PMMP). The PMMP is based on a biopsychosocial model, and focuses on biological, psychological and social supports to manage pain and maintain functionality. The PMMP encourages patients to take control of their treatment plan (self-management), to decrease reliance on opioid medications, and to utilize non-pharmacological treatments to manage their condition.
- The PMMP is a residential treatment service, offered in one of six clinics in BC. Clients stay in residence for up to 18 weeks of treatment. Service components of the PMMP include: comprehensive biopsychosocial functionality assessment conducted by an interdisciplinary team (physician, PT, OT, psychologist, pharmacist) pain and medication management assessment, customized pain treatment services; return to work planning and monitoring; and post discharge follow-up.
- If required, clients also participate in the Medication Management Module a daily in-clinic program to taper the injured worker's use of opioids.
- Other WSBC programs include:
    - Concurrent Care Program Pilot – for workers with concurrent mental health and addiction disorder
    - Community Pain and Addiction Services
    - Home Detox and Medication management
    - Residential Addiction Services
    - Support Recovery Services

[9] Rosenblum, A., Marsch, L. A., Joseph, H., & Portenoy, R. K. (2008). Opioids and the Treatment of Chronic Pain: Controversies, Current Status, and Future Directions. *Experimental and Clinical Psychopharmacology, 16*(5), 405–416. http://doi.org/10.1037/a0013628

- In 2016, in acknowledgement of the overdose emergency, WSBC piloted their Opioid Outreach Education Initiative (OOEI) in four communities. The OOEI provides inperson training sessions to groups of health care providers to support them to address chronic pain. The OOEI has not been yet been evaluated. WSBC is contemplating expanding this program to an additional four to eight communities. MOH has asked WSBC for more information on this program, and an evaluation of the interest, and impact of the program on health care providers.
- MOH, in collaboration with MMHA PainBC and health system partners, is currently undertaking an analysis of gaps and opportunities in chronic non-cancer pain services, and is considering ways to enhance health system supports for people living with chronic pain.

ADVICE:
s.13

Program ADM/Division: Taryn Walsh, ADM, Policy, Monitoring and Evaluation
Program Contact (for content): Cheryl Martin, Director MOH/Carolyn Davison, A/Executive Director, MMHA
Drafters: David Hay/Haley Miller/Cheryl Martin
Date: February 26, 2018

MINISTRY OF MENTAL HEALTH AND ADDICTIONS
DECISION BRIEFING NOTE

Cliff # 1099731

PREPARED FOR: Honourable Judy Darcy, Minister – **FOR DECISION**

TITLE: Class Exemption for Overdose Prevention Services in British Columbia

PURPOSE: To provide an overview of Health Canada's offer to issue provinces and territories class exemptions for overdose prevention services, and propose a provincial response.

BACKGROUND: At the end of 2016, despite significant investments to expand the reach of naloxone and other life-saving interventions, British Columbia experienced an unprecedented increase in overdose harms including death caused by an increasingly toxic illegal drug supply due to the introduction of highly toxic synthetic opioids such as fentanyl and carfentanil into the illegal supply.

In response, the Ministry of Health sought legal advice regarding how to increase the likelihood of rapid intervention with naloxone and other emergency first aid support in the event of an overdose. In December 2016, the Minister of Health issued Ministerial Order M488 under the authority of section 5.2 of the *Emergency Health Services Act* and section 7.1 of the *Health Authorities Act* that allowed for the establishment of overdose prevention services (OPS) to prevent overdose associated mortality.[1] The Order ensures that BC Emergency Health Services and regional health authorities can provide OPS as necessary on an emergency basis for the duration of the public health emergency.

OPS allow people who use drugs to use their illegal drugs in a setting with someone present to monitor them for signs of an overdose, and respond immediately when an overdose occurs. These low-barrier services are often the first point of engagement with people who are not otherwise connected to care or supports. With shifting local circumstances, many provide peer connection to primary care and substance use disorder treatment. Since December 2016, there have been more than 545,000 visits to OPS sites across the province with 2,500 overdoses survived and zero fatalities.[2] Further, there have been no adverse consequences with law enforcement. As of January 2018, there are 45 OPS sites across the province.

British Columbia continues to experience an unacceptable amount of overdose harms and death. As a result, OPS are no longer seen as a temporary measure but rather as a vital service in the provincial response to the overdose emergency. The Government of British Columbia has identified funding for regional health authorities to support the operation and oversight of OPS

[1] Ministerial Order M488. Retrieved from: http://www.bclaws.ca/civix/document/id/mo/mo/2016_m488.
[2] BC Centre for Disease Control. (2017, November 30). *Overdose Data & Reports – Interactive Dashboard*. Retrieved from: http://www.bccdc.ca/health-professionals/clinical-resources/harm-reduction/overdose-data-reports.

from this current fiscal year through to March 31, 2020. BC has also developed provincial operational guidelines to support service providers.[3]

In November 2017, Health Canada announced that it would work with provinces and territories to create a streamlined pathway to establish temporary OPS sites with exemptions under the *Controlled Drugs and Substances Act* if a provincial or territorial Minister of Health indicates an urgent public health need.[4] Health Canada sees OPS as temporary sites with an expectation that many will transition to Supervised Consumption Services (SCS). Health Canada has informed provinces and territories that it will grant temporary 90-day class exemptions with an option to extend.

s.13,s.14,s.16

[3] BC Centre for Disease Control. (2017). *BC Overdose Prevention Services Guide*. Retrieved from: http://www.bccdc.ca/resource-gallery/Documents/BC%20Overdose%20Prevention%20Services%20Guide-Final%20October%202,%202017.pdf.

[4] Health Canada. (2017, November 15). *New federal initiatives to address the opioid crisis*. Retrieved from: https://www.canada.ca/en/health-canada/news/2017/11/new_federal_initiativestoaddresstheopioidcrisis.html.

s.13,s.14,s.16,s.17

Judy Darcy

Approved/Not Approved
Judy Darcy, Minister, Mental Health and Addictions

March 19/18

Date

Program ADM/Division: Taryn Walsh, Mental Health and Addictions
Program Contact (for content): Carolyn Davison, A/Executive Director
Date: March 7, 2018

MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

CLIFF # 1109908

PREPARED FOR: Honourable John Horgan, Premier - **FOR INFORMATION**

TITLE: SAP and Overdose Response

PURPOSE: To provide background on SAP's proposed technological solution to assist with the overdose response

BACKGROUND:

- A subsidiary of SAP SE, SAP Canada is headquartered in Toronto, Ontario.
- Operating in the Canadian market since 1989, SAP Canada serves customers across the country and has a significant research and development presence with labs located in Montreal, Toronto, Waterloo and Vancouver.
- SAP describes itself as the world leader in enterprise applications for information management and analytics (measured by software and software-related service revenue).
- SAP was recognized as one of Canada's Top 100 Employers for 2018[1].
- Staff from the Ministries of Health and Mental Health and Addictions, the Overdose Emergency Response Centre (OERC) and the BC Centre for Disease Control (BCCDC) met briefly with SAP staff on February 7, 2018.
- Honourable Bruce Ralston, Minister of Jobs, Trade and Technology, OERC Operations Director and Senior Ministerial Assistant from Mental Health and Addictions toured the Vancouver offices of SAP on February 8, 2018.
- SAP has proposed to create a technological solution (*SAP Digital Boardroom*) to assist with the overdose response.
- A rough estimate of the annual cost of the *SAP Digital Boardroom* solution was provided by SAP as $250,000-$500,000/year.
- SAP has provided the *SAP Digital Boardroom* (and additional products and services) to the State of Indiana as one of the State's tools in responding to their own opioid overdose emergency[2].

DISCUSSION:

- The *SAP Digital Boardroom* is able to present real-time data in a digital presentation. Essentially, the solution allows for the integration of multiple sources of data into one relational database that includes analytical and data visualization capabilities, and is presented in a user-friendly interface, "suitable for the boardroom".
- The *SAP Digital Boardroom* solution allows data analytics questions to be answered in real time, i.e. during the meetings in which the questions are asked.

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[1] See https://content.eluta.ca/top-employer-sap

[2] SAP provided links to articles and short videos of their work in the State of Indiana: https://www.wired.com/story/indiana-reeling-from-opioid-crisis-arms-officials-with-data/; https://www.youtube.com/watch?v=5rIPwIQr6RE; http://www.in.gov/gov/files/DPTE%20Preliminary%20Action%20Steps.pdf

- The product also facilitates the use and analysis of data by a much wider audience, beyond researchers and data analysis technicians, to assist in decisions around planning health services. For example, providing data to inform where best to scale up access to naloxone to prevent overdose death and addiction treatment e.g. opioid substitution therapy (buprenorphine/naloxone, methadone, slow release oral morphine etc.).
- Such a product can also contribute to the "democratization" of data across sectors and platforms and to multiple audiences, including stakeholders and the public.
- BCCDC is the organization that is funded by government to provide information management and analytics regarding the response to the overdose emergency. BCCDC is in the process of hiring a software developer to work with the *Tableau* "business intelligence" product they currently use. The developer will be working on building quick reference dashboards and other data visualization tools.
- The *SAP Digital Boardroom* solution provides comprehensive and accessible data presentation and analytics that could aid in the response to the overdose emergency.
- In addition to SAP, there are other companies that provide "business intelligence" tools for data integration, analytics and visualization.

ADVICE:

s.13,s.17

Program ADM/Division: Taryn Walsh, Assistant Deputy Minister, Policy, Monitoring and Evaluation
Program Contact (for content): Carolyn Davison, A/Executive Director; Miranda Compton, OERC
Drafter: David Hay, Policy Analyst
Date: March 20, 2018

MINISTRY OF MENTAL HEALTH AND ADDICTIONS
INFORMATION BRIEFING NOTE

Cliff # 1099059

PREPARED FOR: Honourable Judy Darcy, Minister - **FOR INFORMATION**

TITLE: Tool for Primary Care Providers who Prescribe Opioids for Chronic Non-Cancer Pain

PURPOSE: To provide the Minister with information on a guide developed by the Centre for Effective Practice for primary care providers who prescribe opioids for chronic non-cancer pain

BACKGROUND:
The Centre for Effective Practice (CEP) is a Toronto-based not-for-profit organization that develops supports for primary care providers to help close the gap between best evidence and current practice. On November 30, 2017, the CEP sent the Minister of Mental Health and Addictions an updated version of the organization's Opioid Manager (see Appendix A), a clinical tool designed to support primary care providers to manage opioid prescriptions for patients living with chronic non-cancer pain. The Opioid Manager reflects recommendations outlined in the *Guideline for opioid therapy and chronic noncancer pain,* which was published in the Canadian Medical Association Journal in May 2017 (see Appendix B).

In 2016, in response to the overdose epidemic, the College of Physicians and Surgeons of BC changed their guidelines and standards for prescribing opioids, and many physicians have reduced prescribing these medications as a result. The College adjusted the guidelines again in October 2016 (due to a lack of clarity in the first update) and have recently revised the guidelines to align with the McMaster National Opioid Prescribing Guidelines (expected to be released by February 2018).

BC Guidelines are clinical practice guidelines and protocols that provide recommendations to practitioners on delivering high quality, appropriate care to patients with specific clinical conditions or diseases. These "Made in BC" clinical practice guidelines are developed by the Guidelines and Protocol Advisory Committee (GPAC), an advisory committee to the Medical Services Commission. The primary audience for BC Guidelines is BC physicians, nurse practitioners, and medical students. There currently is no guideline for chronic non-cancer pain.

DISCUSSION:
One in five British Columbians lives with chronic pain. Due to a lack of publicly funded alternatives, chronic pain treatment often relies on the prescription of high-dose opioids. Although the drivers of BC's overdose epidemic are complex, it has been suggested that unsafe opioid prescribing practices and unsafe use of prescription opioids have contributed to opioid-related mortality. In addition, people who are dependent on prescribed opioids and can no longer access them, may procure opioids from the illegal drug supply in order to relieve their symptoms. However, the magnitude of this issue is not well understood.

There have been numerous requests of GPAC to develop a chronic non-cancer pain guideline for primary care providers in BC. GPAC will be discussing the need for this at an upcoming meeting, in light of the CPSBC decision to endorse the National Guidelines.

Although guidance promotes and improves understanding and safer prescribing of opioids for chronic non-cancer pain, many primary care providers have expressed concern that the guidance is unlikely to solve British Columbia's opioid crisis, or the under-treatment of those living with chronic pain. In the absence of a comprehensive provincial pain management strategy that publically funds non-opioid alternatives, systemic barriers will continue to be experienced by people living with chronic non-cancer pain, thereby limiting the options for both providers and people living with pain.

The Ministry of Health has been directed to work in partnership with stakeholders, including the Ministry of Mental Health and Addictions, on developing a chronic pain strategy for people living with chronic non-cancer pain.

ADVICE:
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Date: December 27, 2017

OPIOID MANAGER

The Opioid Manager is designed to support health care providers prescribe and manage opioids for patients with chronic non-cancer pain. All information is based on the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain,[1] unless cited otherwise.

This is an update of the original Opioid Manager, released in 2011.

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Developed by:

Centre for Effective Practice

In collaboration with:

UHN

GUIDELINE CPD

Guideline for opioid therapy and chronic noncancer pain

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CMAJ podcasts: author interview at https://soundcloud.com/cmajpodcasts/170363-guide

See related article www.cmaj.ca/lookup/doi/10.1503/cmaj.170431

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MINISTRY OF MENTAL HEALTH AND ADDICTIONS/MINISTRY OF PUBLIC SAFETY AND SOLICITOR GENERAL
INFORMATION BRIEFING NOTE

Cliff # 542705

PREPARED FOR: Honorable Judy Darcy, Minister, Mental Health & Addictions; Honorable Mike Farnworth, Minister, Public Safety and Solicitor General **- FOR INFORMATION**

TITLE: Exploring potential pilot(s) for police referral to timely and direct access to treatment &/or support program

PURPOSE: As part of the continuum of responses to the overdose crisis, this pilot would facilitate direct access to treatment for individuals at risk of opioid overdose through timely police referrals to critical services and supports.

BACKGROUND:
In BC a public safety response to the opioid overdose crisis includes:

- Creation of a dedicated Anti-Trafficking Task Force within the Combined Forces Special Enforcement Unit of British Columbia (CFSEU-BC) to counter the spread of street-level fentanyl-related compounds and derivatives, their trade and associated gun violence;
- Protection of officers from exposure while they do their dangerous work, through Naloxone supply and training, as well as special equipment such as detection and protective gear;
- Provision of more support for police-based outreach in their own communities; and
- Expansion of the B.C. Coroners Service Drug-Death Investigations Team, to meet the significant increase in workload and lab testing, providing timely, accurate data to inform new strategies in this public health crisis.

While not directly applicable to Canada, of some US police forces directly refer individuals with substance use problems to case management and treatment to reduce opioid overdose deaths and achieve other positive outcomes. Early evaluation has been promising.[1] In some jurisdictions, such as Seattle, referrals/diversion to treatment take place pre-booking and allows officers to redirect low-level offenders engaged in drugs or prostitution activity to community-based services instead of jail and prosecution.

In BC a police-based direct referral and placement approach (See Appendices A and B for an outline of the "treatment on Demand" VPD proposal and of the Gloucester, Mass. "Angel Program") would support the philosophy that recognises addiction as primarily a health matter. Accordingly, PSSG and MMHA are exploring the potential to pilot a police-based referral program for timely and direct access to treatment and support services for individuals at high risk of overdose in one or more BC communities, and assessing health, social and public safety outcomes.

[1] See http://paariusa.org/wp-content/uploads/sites/46/2017/12/How-do-we-know-this-is-working-Gloucester-Angel-Program.pdf

It's important to remember that police agencies operate at arm's length from government and decisions related to enforcement are the sole responsibility of those agencies. Individual police officers have discretion to refer or not to refer regardless of the pilot. Additionally, municipal police agencies are governed by independent police boards who are responsible to set overall strategic priorities for their police departments.

DISCUSSION:

Core elements of a BC pilot to be conducted in up to three communities would include:

1. Identification of community goals associated with the approach, including:
    a. Reduced risk of overdose death
    b. Improved health and social status of individuals referred
    c. Reduced public safety system involvement
    d. Other community goals as determined
2. A gap analysis and mapping of available services to support a continuum of care within the community.
3. Establishment local agreements among police, regional health authorities (treatment services and intensive case management) and housing providers on roles, functions and referral pathways to support direct placement in appropriate programs.
4. Agreements on service accessibility, after-hours services, relapse management
5. Identification of referral criteria including high risk of opioid overdose; local communities may wish to identify additional criteria.
6. Measurement outcomes will be based on the identified community goals.

ADVICE & NEXT STEPS:

- The Overdose Emergency Response Centre is identifying a short-list of priority communities where there is interest in piloting the approach, and where treatment and case management capacity could be aligned for direct and timely access response upon referral.

- PSSG Policing and Security Branch will support discussion with police agencies interested and willing to participate in a pilot.

- PSSG and the Overdose Emergency Response Centre will assist up to three interested communities to develop local models and evaluation frameworks. The coordination and realignment of resources will be determined, and any additional resource requirements identified.

- Status update BN will be provided to the Minister of Mental Health and Addictions and the Solicitor General in April 2018.

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Appendix A: Angel Program
Appendix B: Vancouver Police Department (VPD), Treatment on Demand Recommendations

APPENDIX A: Angel Program

At the widely acclaimed **Angel Program** in Gloucester, Massachusetts, drug users who seek help at the police station are immediately linked with on-call volunteers — known as "angels" — who accompany the individual to an emergency room, if needed, and help find withdrawal management, treatment, and other services afterward. Drug users leave any drugs at the station and do not face criminal charges.

A similar model has been adopted by the Arlington, Massachusetts police department and at police departments in many US states.

Core elements of the Gloucester and Arlington models:

1. Drug users who walk into a police station and ask for help are linked to treatment, with the support of an on-call volunteer or designated case manager, without any legal action. The volunteer accompanies the drug user at Emergency if needed, and during case management/treatment intake.

2. While primarily relying on referral and placement in publicly available services, some US police departments reach direct agreements with private health and social service providers and use fund-raised resources to bridge costs ensuring immediate access while individuals are on public system wait lists.

3. Naloxone is provided at no cost to the drug user and his or her family and friends to prevent overdose death.

4. If a drug user has an interaction with an officer on the streets or in the community, the officer may refer him or her to the program.

The core elements developed by police forces in other cities differ slightly in their detail. Gloucester police chief, Chief Leonard Campanello: "*We are not trying to set a national model here. We're not trying to say what's good for other communities. We're basically saying what works for Gloucester. We listened to the citizens of the city to see how they wanted their police department to react to this crisis and came up with this plan. I think that each law enforcement entity in any city has to do the same thing, listen to what the citizens are saying, that's pretty much how we work…*"[2]

In Gloucester, outcomes achieved in the short to medium term have been impressive, especially in terms of success in immediate placement in withdrawal management and similar services. Longer term outcomes are less clear—in part due to the fractured nature of Massachusetts' publicly funded treatment system, and further evaluation is required.[3]

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[2] Siegel, Z. (2015). How the Gloucester, Massachusetts Police are Showing that Addiction is Not a Crime. *The Fix, Addiction and Recovery*. Available at https://www.thefix.com/content/addiction-not-crime-Gloucester-Campanello0612

[3] Davida M. Schiff, Mari-Lynn Drainoni, Zoe M. Weinstein, Lisa Chan, Megan Bair-Merritt, David Rosenbloom. (2017). A police-led addiction treatment referral program in Gloucester, MA: Implementation and participants' experiences, *Journal of Substance Abuse Treatment,* Volume 82, pp. 41-47.

Appendix B: Vancouver Police Department (VPD): Treatment on Demand

In May 2017, the Vancouver Police Department (VPD) publically released a report, *The Opioid Crisis: The Need for Treatment on Demand*, which included five recommendations to address the overdose crisis. The recommendations focused on addressing significant gaps in treatment and recovery services and were informed by VPD's partnerships with physicians and addictions experts, research of senior medical professionals, existing research studies, the outcomes of the BC Overdose Action Exchange and Dr. Perry Kendall. [4] The report recommendations included:[5]

1. Expand federal and provincial government support and accountability, including a governance and accountability structure with real-time data analysis and professional oversight ensuring a coordinated response to the overdose emergency.
2. Expand and provide more funding for evidence-based addiction treatment, including opioid-assisted therapy programs. This includes supervised injectable opioid agonist treatment.
3. Create a system for immediate evidence-based addiction treatment and concurrent mental health crisis intervention and support, including:
    a. Increased inpatient beds and sufficient community mental health and addictions services;
    b. 24/7 system to ensure immediate access to treatment for individuals referred by first responders; and
    c. Care models aimed at supporting acute addiction care through to recovery including supportive recovery housing and long term addiction treatment beds.
4. Address the lack of health care information to allow for the creation of data-driven strategies. Ensure that information and data gaps are address such as:
    a. System to track waitlists and link between withdrawal management programs and ongoing evidence-based addiction care;
    b. Data to provide information about standards and outcomes for supportive recovery housing and longer term addiction treatment beds;
    c. System to provide an appropriate level of information to front line service providers to address needs of individuals at risk e.g. following an overdose/emergency room visit;
    d. Drug testing and other metrics to inform the creation of an early warning system;
    e. Comprehensive study to determined population with opioid dependency across Canada;
    f. Review and gap analysis by internationally recognized experts; and
    g. Mandatory data collection of all overdoses and overdose deaths, and monthly reporting.
5. Increase public awareness to support prevention through education, including overdose symptoms, the dangers of Fentanyl and prevention information. Information to be shared in public areas, in universities and in primary and secondary schools.

[4] Vancouver Police Department. (2017). The Opioid Crisis: The Need for Treatment on Demand. Retrieved from http://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf.
[5] Vancouver Police Department. (2017). The Opioid Crisis: The Need for Treatment on Demand. Retrieved from http://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf.