

## Yamashita, Ann MMHA:EX

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**From:** Davison, Carolyn J MMHA:EX  
**Sent:** September 13, 2019 1:02 PM  
**To:** Tupper, Kenneth HLTH:EX  
**Subject:** Draft BN SUAP  
**Attachments:** Briefing Note - Information BN SUAP 2019.docx; Appendix A - BC SUAP-Funded Projects.docx

Hi Ken

Any suggested changes, concerns, questions?

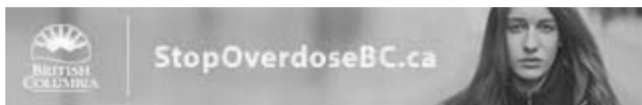
Take care,

Carolyn

**Carolyn Davison** | Director | Overdose Evaluation & Monitoring | Overdose Emergency Response Centre | Strategic Priorities & Initiatives Division | Ministry of Mental Health and Addictions | PO Box 9672 Stn Prov Govt, Victoria, BC, V8W 9P1 | ph: 250-952-3674 c: 250-893-2330 | [carolyn.davison@gov.bc.ca](mailto:carolyn.davison@gov.bc.ca)

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

**Cliff #**

**PREPARED FOR:** Taryn Walsh, Assistant Deputy Minister - **FOR INFORMATION**

**TITLE:** B.C. Submissions related to Anticipatory Call for Proposals – Health Canada’s Substance Use and Addictions Program (SUAP) and Public Health Agency of Canada’s (PHAC) Letter of Intent (LOI) for Supporting Pathways to Care for People Who Use Drugs.

**PURPOSE:** To provide background the known submissions from B.C. for SUAP funding due September 26, 2019 and PHAC LOI Supporting Pathways due August 20, 2019.

**BACKGROUND:**

Health Canada's SUAP provides approximately \$50 million annually in grants and contributions funding annually to other levels of government, community-led and not-for-profit organizations to respond to drug and substance use issues in Canada.

SUAP funds evidence-informed and innovative problematic substance use prevention, harm reduction and treatment initiatives across Canada at the community, regional and national levels. Initiatives target a range of psychoactive substances, including opioids, stimulants, cannabis, alcohol, nicotine and tobacco.

SUAP recently launched a one-time anticipatory call for proposals. Funding will be available, to enhance the response to the overdose crisis and other emerging issues, such as methamphetamines with a deadline for submission of September 26, 2019. Under this call for proposals, funding will be provided to projects in three streams:

**Stream 1: Harm reduction, community-led and front-line initiatives** – projects that meet the needs of their communities as they respond to their problematic substance use issues. For example: projects that facilitate new or expanded access to harm reduction services and practices; which connect a range of services in an area to provide better wrap-around care or case management; that offer opioid agonist treatment (OAT) in underserved communities, or which help direct people towards the health and social services they need.

**Stream 2: Increasing access to pharmaceutical-grade medications** - initiatives designed to provide pharmaceutical-grade medications as safer alternatives to the contaminated illegal drug supply in Canada (referred to by some stakeholders as "safe supply"). The funding may be used by pilot projects to purchase pharmaceutical-grade medications.

**Stream 3: New approaches to address problematic methamphetamine use** – projects that pilot new approaches to address problematic methamphetamine use, build knowledge of effective interventions and improve access to services.

Note: SUAP funding cannot be used for the ongoing operations and services of supervised consumption sites (SCS) and/or overdose prevention sites (OPS). However, SCS/OPSs are eligible to apply for funding for time-limited projects that pilot a new service. For example, an existing SCS/OPS could apply to run a pilot project that provides clients with pharmaceutical-grade opioids as an alternative to illegal drugs, as per the project criteria under Stream 2: Increasing Access to Pharmaceutical Grade Medications.

Note: Applications under Stream 2 must demonstrate (a) linkages to provincial health system, health authorities, regulatory bodies, compliance with all existing regulations, and formal commitment from and access to relevant health professionals; (b) involve prescriber oversight in the context of a patient-prescriber relationship; (c) plan for ethics review; (d) commitment to participate in a third-party evaluation, and (e) involve people with lived and living experience.

PHAC recently invited applications for funding for projects that catalyze system-level change to enhance pathways to care for people who use drugs with an investment of \$3.5 million. The deadline for submissions was August 30, 2019.

## **DISCUSSION:**

Currently, there are 23 projects based in B.C. that have received Health Canada SUAP funding for a total of \$29.7 million (See Appendix A). For example, the BCCDC is working on a SUAP-funded pilot project to prevent overdose by providing low-barrier access to hydromorphone pills to people who use opioids. Of note, Dr. Mark Tyndall, a professor at the University of British Columbia's School of Population and Public Health, is independently working on a separate project to make hydromorphone pills available via dispensing machines. Dr. Tyndall's project is not funded by SUAP or the provincial government.

Pharmaceutical alternatives reduce harms, reduce the risk of overdose/poisoning by separating people who use illegal drugs from the illegal market, improve social functioning and social integration, increase HIV treatment adherence and can reduce hepatitis C infection.

The Ministry of Mental Health and Addictions (MMHA), in collaboration with the Office of the Provincial Health Officer (PHO), Ministry of Health (MoH), BC Centre for Substance Use (BCCSU), BC Centre for Disease Control (BCCDC), and health authorities are examining ways to increase access to programs that provide prescription-grade opioid medications as alternatives to illegal street drugs.

There is broad support for pharmaceutical alternatives: BC PHO, Chief Medical Health Officer for Vancouver Coastal Health Authority, City of Vancouver Task Force and Mayor, Government of Canada (current grant call for proposals to increase access pharmaceutical options in the context of the overdose response), Vancouver Police Department (2017 position paper), the BC Overdose Action Exchanges (206, 2017 and 2018 reports), Community Action Teams, BC Centre for Disease Control (BCCDC), BC Centre on Substance Use (BCCSU), addiction and public health physicians, BC Nurses and people with lived and living experience.

There are several proposals incubating in BC that may secure SUAP funding. MMHA is aware of three projects going forward for federal funding - two for SUAP and one that went forward for PHAC funding:

1. UBC, VCH, BCCDC (SUAP: \$1,275,000): *Preventing Overdose Deaths by Providing Buprenorphine/Naloxone to High Risk Emergency Department (ED) Patients*

This project will refine ED screening protocols to identify patients with an opioid use disorder (OUD) and implement and evaluate ED initiated buprenorphine/naloxone offering standard take-home dosing and micro-dosing packages at four BC and Alberta EDs. The project will develop a Knowledge Toolkit to allow program scale-up to additional Canadian sites, leveraging our provincial and national emergency medicine networks.

2. VCH, VIHA, BCCSU (SUAP: amount TBD). *SAFER Initiative: Safer Access for Emergency Response*

Proposal to address the population who use illegal drugs, are at high risk of overdose due to the toxic illicit drug supply, but opioid use pattern does not make them eligible for traditional OAT/iOAT (injectable OAT) - perhaps because their primary use involves different drugs and they only intermittently use opioids or have not been adequately maintained on these treatments. This program would involve providing a pharmaceutical grade opioid (e.g. hydromorphone tablets, hydromorphone, powdered morphine) to individuals who have an OUD but are not being adequately maintained on OAT or iOAT; or, for individuals who have a substance use disorder and are intermittent users of opioids and have high risk of overdose and death. Two sites, up to 700 patients/site, \$1.5M/year per site, up to four years of funding, including drug costs and staffing costs: peer navigators, nurses, physicians/nurse practitioners.

- 3.

s.13; s.17

While formal provincial government support is not required, MMHA does provides letters of support to organizations applying for funding (e.g. SUAP, PHAC, CIHR, MSFHR) where the projects align with the mandate of the Ministry.

MMHA has reached out to the health authorities to find out what other proposals for federal funding may be coming from BC. Additionally, MMHA has reached out to Health Canada requesting information on proposals from BC.

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**Telephone:** 778-698-3096

**Program Contact (for content):** Carolyn Davison, Director, Overdose Evaluation & Monitoring

**Drafter:** Carolyn Davison

**Date:** 2019-09-13

**File Name with Path:**



APPENDIX A: BC SUAP-FUNDED PROJECTS

Organization	Project Title	City	Description	Focus	Pillar	Duration	Total \$
<b>BC Centre for Disease Control</b>	<i>Peer 2 Peer Support</i>	Vancouver	The project team is engaging peers with lived experience working as first responders in two overdose response environments in Coquitlam and Victoria to develop, implement and evaluate a peer-led model of supports addressing issues of stress management, trauma and burnout facing peers in their work as first responders in overdose situations.	Opioids	Harm Reduction	36 months	\$292,675
<b>Centre of Excellence for Women's Health Society</b>	<i>Women, opioids, stigma and harm reduction responses.</i>	Vancouver	This initiative will gather and synthesize evidence on stigma experienced by women who use opioids during their interactions with child welfare organizations; align this evidence with that on sex, gender and equity-informed harm reduction and treatment approaches to opioid use among women; and co-create with collaborating partners a multi-component toolkit comprised of resources to guide system planners and practitioners in both child welfare and substance use systems across Canada.	Opioids	Harm Reduction	18 months	\$224,789

# APPENDIX A: BC SUAP-FUNDED PROJECTS

<b>Centre of Excellence for Women's Health Society</b>	<i>Prevention, harm reduction and the route of administration (ROA): aligning cannabis, tobacco use and vaping</i>	Vancouver	This initiative will develop a sex, gender and equity informed framework and an infographic for cannabis routes of administration, focusing on combustible and vaping formats. Feasibility and utility of the framework and infographic would be evaluated with 150 participants from across Canada working in the field of substance use prior to broader dissemination. The infographic will be a practical tool for clinicians, researchers, program planners and the public, and will include information on the relative harms of vaping different forms of cannabis in comparison to tobacco smoking and/or nicotine vaping.	Cannabis	Prevention / Harm Reduction	15 months	\$178,333
<b>Dr Peter Aids Foundation</b>	<i>Overcoming barriers to iOAT: An implementation evaluation of iOAT in an integrated health care facility for health service organizations across Canada</i>	Vancouver	This initiative will implement and evaluate an intravenous Opioid Agonist Therapy program in an integrated health setting for people who use injection drugs (Dr. Peter Centre). Findings from the evaluation including impact on drug-related harms (e.g. overdose), HIV treatment adherence, and health outcomes will be shared with health service organizations, public health and health care professionals and policy makers across Canada to provide them with knowledge and support to inform the implementation of iOAT in their organizations.	Opioids	Harm Reduction	30 months	\$2,676,975

APPENDIX A: BC SUAP-FUNDED PROJECTS

<b>Government of BC</b>	<i>Opioid Agonist Treatment (OAT) Training for BC Pharmacists</i>	Victoria	This initiative will provide training for pharmacists participating in opioid agonist treatment in order to increase pharmacists' knowledge on buprenorphine, naloxone and slow-release oral morphine.	Opioids	Treatment	48 months	\$950,458
<b>Providence Health Care</b>	<i>Building Capacity for Early Intervention: Increasing Access to Youth-Centred, Evidence-Based Substance Use and Addictions Services in BC and Ontario</i>	Vancouver	This initiative will develop an evidence-based intervention to screen, treat and provide long-term support for youth with substance use problems, particularly opioids, cannabis and alcohol, and study the impact of this intervention on youth living in diverse communities in BC and Ontario.	Multiple substances	Treatment		\$1,899,239

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<b>Provincial Health Services Authority (BC Centre for Disease Control)</b>	<i>A feasibility pilot of low barrier oral hydromorph one to prevent fatal overdoses</i>	Vancouver	This initiative is providing a safer alternative to illegal opioids, hydromorphone (Dilaudid), to people who use drugs. The goal of this project is to reduce overdose deaths in individuals at high risk due to their use of illegal opioids by providing a safer alternative. This pilot project is also connecting people who use drugs and are not currently accessing conventional harm reduction and treatment services to health and social supports.	Opioids	Harm Reduction	36 months	\$1,437,167
<b>Provincial Health Services Authority (BC Centre for Disease Control)</b>	<i>Developing A National Surveillance of Illicit Drug Content</i>	Vancouver	This initiative will pilot a drug surveillance system in order to inform behaviour, policies and services based on accurate information on the illegal street drug supply.	Opioids		36 months	\$706,849

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<b>Simon Fraser University (BC Centre for Excellence in HIV/AIDS)</b>	<i>Towards a Comprehensive performance measurement system for Opioids use disorder in British Columbia, Canada</i>	Vancouver	This initiative would develop a comprehensive, rigorously-defined set of health system performance measures for people with opioid use disorders (PWOD). This suite will include a cascade of care to quantify the target population's engagement with the health system and enable stakeholders to identify gaps in retention, and opportunities for re-engagement. The cascade of care will be complemented with clinical guideline compliance and care integration measures to maximize the technical efficiency of health care services provided.	Opioids	Treatment	48 months	\$1,265,355
<b>Simon Fraser University 2 (Canadian Drug Policy Coalition)</b>	<i>Building Capacity and Moving to Consensus: A Canadian Dialogue on a Public Health Approach to Drugs</i>	Vancouver	This initiative will reduce stigma associated with substance use among decision-makers and public, build decision-makers capacity to implement health promotion and harm reduction systems and increase national awareness of drug related issues by facilitating community dialogues and creating knowledge translation tools.	Opioids		36 months	\$2,314,862

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<b>St. John Ambulance BC and Yukon Council</b>	<i>Opioid Overdose Response Training – Occupational First Aid</i>	Vancouver	This initiative would redesign the Occupational First Aid training to address opioid overdose by integrating two components proven to effectively reverse drug overdoses when used in combination; naloxone administration and artificial respiration and deliver it to the existing 22 branches located across British Columbia and Yukon.	Opioids	Harm Reduction	24 months	\$413,861
<b>St. Paul's Foundation of Vancouver (BC Centre for Excellence in HIV/AIDS)</b>	<i>The Best-Practices in Oral Opioid Agonist Therapy (BOOST) Collaborative</i>	Vancouver	This initiative will bring together professionals providing oral opioid agonist therapy services to increase the use of best-practices in order to improve treatment and care.	Opioids	Treatment	23 months	\$399,534
<b>St. Paul's Foundation of Vancouver (BC Centre on Substance Use)</b>	<i>Drug Checking as a Public Health Response to Toxic Street Drug Supply</i>	Vancouver	The British Columbia Centre on Substance Use would develop and implement drug checking program sites in Vancouver, Surrey and Kamloops for people who use drugs to have street drugs tested in real-time or sent to a lab for more in-depth testing. Findings from a formal evaluation partnership agreement between BCCSU and St. Michael's Hospital drug checking projects will provide evidence of potential impact of drug checking services on the overdose risk	Opioids	Harm Reduction	60 months	\$2,972,596

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			experienced by vulnerable drug-using populations.				
<b>St. Paul's Foundation of Vancouver (BCCSU)</b>	<i>BC-Yukon Opioid Agonist Treatment (OAT) Provider Network</i>	Vancouver	This initiative will develop an opioid agonist treatment provider network to address the need for evidence-based addiction treatment with particular focus on rural and remote providers.	Opioids	Treatment	48 months	\$933,931
<b>University of BC</b>	<i>Monitoring Drug Impaired Driving in Canada</i>	Vancouver	This initiative will monitor the rate of impairing drugs and report trends and demographic and regional patterns of drug use in injured drivers from across Canada.	Multiple substances		36 months	\$1,361,356

APPENDIX A: BC SUAP-FUNDED PROJECTS

<b>University of BC</b>	<i>Risk Assessment and Management Platform (RAMP): An Online Overdose Risk Score System with Tailored Feedback to Improve access and connect Users to Existing Resources and Improve Their Long-term Overdose Risk.</i>	Vancouver	This initiative will create an online platform to help people who use opioids and their support networks to identify risk factors for overdose and manage high risk behaviours. The platform would provide online risk management resources and tools to help improve access to care for people who use drugs. This will include offering tailored guidance to manage individual behaviour and access to appropriate resources to reduce an individual's risk of fatal and non-fatal overdose incidents.	Opioids	Harm Reduction	36 months	\$1,277,829
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University of BC	<i>Trauma at the Root: Exploring Paths to Healing with Formerly Incarcerated Men</i>	Vancouver	This initiative will engage formerly incarcerated men (FIM) to explore the relationship between trauma and substance use to inform policies, programs, and practices for this target population. The initiative will develop a comprehensive trauma education kit and associated knowledge translation strategies to support the integration of trauma into correctional institutions and community-based organizations providing services to currently and formally incarcerated men. The intended impact would be to decrease the risk for problematic substance use and support the successful reintegration of FIM.	Multiple substances		52 months	\$558,180
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<b>University of BC</b>	<i>ROAR: Reducing Overdose And Relapse: Concurrent Attention to Neuropsychiatric Ailments and Drug Addiction (ROAR CANADA)</i>	Vancouver	This initiative will undertake the study of two new integrated recovery programs in Canada that were developed in response to the lack of capacity in treating severely addicted and mentally ill individuals and have shown efficacy in preliminary assessments. This study will assess and analyze a sufficient number of specific individual and organizational factors on severe concurrent disorder, to gain knowledge about critical subgroups (e.g., women, LGBTQ2S, people from rural and remote areas, homeless and Indigenous people) and monitor the transition of individuals from inpatient treatment back into their community.	Multiple substances		60 months	\$1,599,565
<b>University of British Columbia</b>	<i>A comprehensive online detection and intervention approach to opioid and alcohol use in university students</i>	Vancouver	This initiative will develop and implement a comprehensive online approach to screening university students for substance use and mental disorders, with a focus on opioid, alcohol and cannabis use. Coached e-interventions to manage stress, anxiety, depression, risk and relapse will be provided to prevent the emergence of problematic opioid and alcohol use.	Multiple substances		36 months	\$3,260,065

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<b>University of Victoria - Centre for Addiction Research of BC</b>	<i>Promoting Health and Reducing Harm Through Public Policy and Citizen Engagement</i>	Victoria	This project is comprised of two streams: 1) increase uptake of policies proven to reduce the levels of alcohol-related harms in Canada and 2) engage communities in dialogue about cannabis and cannabis policy.	Multiple substances (alcohol - cannabis)		26 months	\$1,397,504
<b>University of Victoria - Department of Chemistry</b>	<i>Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose</i>	Victoria	This initiative will implement drug checking services by integrating data surveillance and evaluating different drug checking devices and technologies.	Opioids	Harm Reduction	36 months	\$1,700,963
<b>University of Victoria - Canadian Institute for Substance Use Research</b>	<i>The Substance Use Response Observatory: To Monitor and Inform Public Responses to Drug Use</i>	Victoria	This initiative will develop a stakeholder-informed provincial network of people who use substances and their families, community service providers, regional health authorities, and provincial government. The network would generate and report timely and actionable evidence on substance use, related harms, costs, structural vulnerability and community responses to reduce substance-related harms.	Multiple substances		60 months	\$1,901,357
<b>Vancouver Island University</b>	<i>Drug Checking Technology Challenge</i>	Vancouver	Drug Checking Technology Challenge	Opioids	Harm Reduction		\$25,000
<b>Total</b>							<b><u>\$29,748,443</u></b>

## Yamashita, Ann MMHA:EX

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**From:** Davison, Carolyn J MMHA:EX  
**Sent:** September 23, 2019 2:43 PM  
**To:** Simpson, Tammy (HC/SC)  
**Cc:** Emslie, Margaret J HLTH:EX; Tupper, Kenneth HLTH:EX  
**Subject:** BC-SUAP proposals

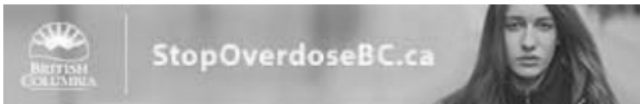
Hi Tammy

Thank you for agreeing to share the BC proposals for the latest anticipatory call for proposals. When you send them through, can you copy Ken Tupper and Meg Emslie copied here? We will coordinate together a joint response back from BC to ensure alignment with BC's strategic priorities, mandates, and prevent duplication with existing interventions, services and supports.

Take care,  
Carolyn

**Carolyn Davison** | Director | Overdose Evaluation & Monitoring | Overdose Emergency Response Centre | Strategic Priorities & Initiatives Division | Ministry of Mental Health and Addictions | PO Box 9672 Stn Prov Govt, Victoria, BC, V8W 9P1 | ph: 250-952-3674 c: 250-893-2330 | [carolyn.davison@gov.bc.ca](mailto:carolyn.davison@gov.bc.ca)

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## Yamashita, Ann MMHA:EX

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**From:** Davison, Carolyn J MMHA:EX  
**Sent:** September 23, 2019 2:38 PM  
**To:** Tupper, Kenneth HLTH:EX; Emslie, Margaret J HLTH:EX; Thomas, Gerald HLTH:EX  
**Cc:** Perkin, Kathleen M HLTH:EX  
**Subject:** FYI - Current BC-funded projects  
**Attachments:** SUAP projects\_BC\_Sept 13 2019.xlsx

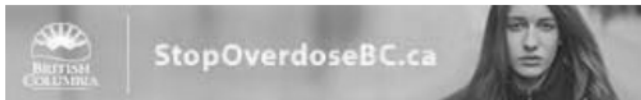
Apparently there is another coming soon with

s.17

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University of BC	<i>Risk Assessment and Management Platform (RAMP): An Online Overdose Risk Score System with Tailored Feedback to Improve access and connect Users to Existing Resources and Improve Their Long-term Overdose Risk.</i>	Vancouver	BC	This initiative will create an online platform to help people who use opioids and their support networks to identify risk factors for overdose and manage high risk behaviours. The platform would provide online risk management resources and tools to help improve access to care for people who use drugs. This will include offering tailored guidance to manage individual behaviour and access to appropriate resources to reduce an individual's risk of fatal and non-fatal overdose incidents.	Opioids	Harm Reduction	36 months	\$1,277,829
University of BC	<i>Trauma at the Root: Exploring Paths to Healing with Formerly Incarcerated Men</i>	Vancouver	BC	This initiative will engage formerly incarcerated men (FIM) to explore the relationship between trauma and substance use to inform policies, programs, and practices for this target population. The initiative will develop a comprehensive trauma education kit and associated knowledge translation strategies to support the integration of trauma into correctional institutions and community-based organizations providing services to currently and formally incarcerated men. The intended impact would be to decrease the risk for problematic substance use and support the successful reintegration of FIM.	Multiple substances		52 months	\$558,180
University of BC	<i>ROAR: Reducing Overdose And Relapse: Concurrent Attention to Neuropsychiatric Ailments and Drug Addiction (ROAR CANADA)</i>	Vancouver	BC	This initiative will undertake the study of two new integrated recovery programs in Canada that were developed in response to the lack of capacity in treating severely addicted and mentally ill individuals and have shown efficacy in preliminary assessments. This study will assess and analyze a sufficient number of specific individual and organizational factors on severe concurrent disorder, to gain knowledge about critical subgroups (e.g., women, LGBTQ2S, people from rural and remote areas, homeless and Indigenous people) and monitor the transition of individuals from inpatient treatment back into their community.	Multiple substances		60 months	\$1,599,565
University of British Columbia	<i>A comprehensive online detection and intervention approach to opioid and alcohol use in university students</i>	Vancouver	BC	This initiative will develop and implement a comprehensive online approach to screening university students for substance use and mental disorders, with a focus on opioid, alcohol and cannabis use. Coached e-interventions to manage stress, anxiety, depression, risk and relapse will be provided to prevent the emergence of problematic opioid and alcohol use.	Multiple substances		36 months	\$3,260,065
University of Victoria - Centre for Addiction Research of BC	<i>Promoting Health and Reducing Harm Through Public Policy and Citizen Engagement</i>	Victoria	BC	This project is comprised of two streams : 1) increase uptake of policies proven to reduce the levels of alcohol-related harms in Canada and 2) engage communities in dialogue about cannabis and cannabis policy.	Multiple substances (alcohol - cannabis)		26 months	\$1,397,504
University of Victoria - Department of Chemistry	<i>Implementing Innovations in Drug Checking: A Harm Reduction Pilot in Response to Illicit Drug Overdose</i>	Victoria	BC	This initiative will implement drug checking services by integrating data surveillance and evaluating different drug checking devices and technologies.	Opioids	Harm Reduction	36 months	\$1,700,963
University of Victoria - Canadian Institute for Substance Use Research	<i>The Substance Use Response Observatory: To Monitor and Inform Public Responses to Drug Use</i>	Victoria	BC	This initiative will develop a stakeholder-informed provincial network of people who use substances and their families, community service providers, regional health authorities, and provincial government. The network would generate and report timely and actionable evidence on substance use, related harms, costs, structural vulnerability and community responses to reduce substance-related harms.	Multiple substances		60 months	\$1,901,357



<b>Vancouver Island University</b>	<i>Drug Chekcing Technology Challenge</i>	Vancouver	BC	Drug Chekcing Technology Challenge	Opioids	Harm Reduction		\$25,000
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## Yamashita, Ann MMHA:EX

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**From:** Davison, Carolyn J MMHA:EX  
**Sent:** September 10, 2019 2:09 PM  
**To:** Hayward, Ross HLTH:EX  
**Cc:** Tupper, Kenneth HLTH:EX; Yee, Arthur MMHA:EX; Dillon, Mirelle MMHA:EX  
**Subject:** RE: SUAP Proposal: Preventing Overdose Deaths by Providing Buprenorphine/Naloxone to High Risk Emergency Department Patients

Hi Ross

Further to this note, Taryn is planning to reach out generally around the process for SUAP grants.

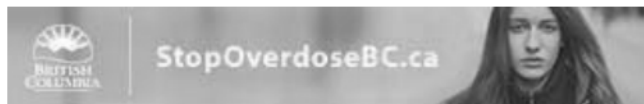
Take care,

Carolyn

**Carolyn Davison** | Director | Overdose Evaluation & Monitoring | Overdose Emergency Response Centre | Strategic Priorities & Initiatives Division | Ministry of Mental Health and Addictions | PO Box 9672 Stn Prov Govt, Victoria, BC, V8W 9P1 | ph: 250-952-3674 c: 250-893-2330 | [carolyn.davison@gov.bc.ca](mailto:carolyn.davison@gov.bc.ca)

Office Location:

1515 Blanshard St., 1<sup>st</sup> Floor



---

**From:** Davison, Carolyn J MMHA:EX  
**Sent:** September 10, 2019 2:39 PM  
**To:** Hayward, Ross HLTH:EX <[Ross.Hayward@gov.bc.ca](mailto:Ross.Hayward@gov.bc.ca)>  
**Cc:** Tupper, Kenneth HLTH:EX <[Kenneth.Tupper@gov.bc.ca](mailto:Kenneth.Tupper@gov.bc.ca)>; Yee, Arthur MMHA:EX <[Arthur.Yee@gov.bc.ca](mailto:Arthur.Yee@gov.bc.ca)>; Dillon, Mirelle MMHA:EX <[Mirelle.Dillon@gov.bc.ca](mailto:Mirelle.Dillon@gov.bc.ca)>  
**Subject:** SUAP Proposal: Preventing Overdose Deaths by Providing Buprenorphine/Naloxone to High Risk Emergency Department Patients

Hi Ross

Please find attached request for s.13; s.17 Wondering if you have any concerns before Taryn signs? Due date is September 20<sup>th</sup>. A summary of the project is cut and pasted below. This project aims to develop emergency department (ED) screening protocols to identify ED patients with opioid use disorder and implement and evaluate ED-initiated buprenorphine/naloxone programs offering take-home standard dosing and microdosing packages at four B.C. and Alberta EDs.

### SUAP Project Summary

Many underserved populations with disproportionate overdose risk (e.g., First Nations, construction workers, people using alone) may present only to emergency departments (EDs).<sup>[1],[2],[3]</sup> ED visits are therefore crucial opportunities to identify them and initiate care.<sup>[4]</sup> In 2017, 58.5% and 82.3% of people who sustained fatal and non-fatal overdoses in B.C. visited EDs in the previous year, for both substance use-related and unrelated reasons.<sup>[5],[6]</sup>

ED-initiated buprenorphine/naloxone is effective in engaging patients in addictions care.<sup>[7]</sup> Yet, most Canadian EDs lack buprenorphine/naloxone initiation programs, and multiple barriers remain to widespread

uptake. Barriers include patients' hesitation about needing to be in significant withdrawal prior to standard dosing inductions, and fears about risk of precipitated withdrawal.[8] Lack of provider comfort/education, time, and institutional support are major challenges, especially in busy EDs.[9]

Microdosing, a novel approach, could mitigate many barriers to buprenorphine/naloxone initiation. Patients immediately start taking low doses that increase slowly over 6-7 days, without prerequisite withdrawal. Risk of precipitated withdrawal is low. Case series are promising, however no rigorous evaluations exist.[10],[11]

This project will first, implement and iteratively refine evidence-informed ED screening protocols to identify ED patients with opioid use disorder. Second, we will implement and evaluate ED-initiated buprenorphine/naloxone programs offering take-home standard dosing and microdosing packages at four B.C. and Alberta EDs. Our program will be the first to implement and evaluate microdosing in the ED. Finally, we will develop a Knowledge Toolkit to allow program scale-up to additional Canadian sites, leveraging our provincial and national emergency medicine networks.

[1]Belzak L, Halverson J. The opioid crisis in Canada: A national perspective. Health Promot Chronic Dis Prev Can 2018, Jun;38(6):224-33.

[2]Statistics Canada. Drug overdose crisis: Socioeconomic characteristics of those dying of illicit drug overdoses in British Columbia, 2011 to 2016. The Daily. 2018, November 13.

[3]Ministry of Mental Health and Addictions. Understanding Why People Use Substances Alone: Listening to Those with Lived Experience. 2018. Available from:  
<https://www2.gov.bc.ca/gov/content/governments/services-for-government/service-experience-digital-delivery/service-design/case-studies/why-do-people-use-substances-alone>.

[4]D'Onofrio G, McCormack RP, Hawk K. Emergency Departments – A 24/7/365 Option for Combating the Opioid Crisis. NEJM 2018;379: 2487-90.

[5]BC Centre for Disease Control. Knowledge Update: Preliminary Results from the 2017 B.C. Provincial Overdose Cohort Refresh. 2019, May. <http://www.bccdc.ca/health-professionals/data-reports/overdose-response-reports>

[6]BC Centre for Disease Control. Knowledge Update: Analyzing patterns of health care utilization among people who overdose from illegal drugs in British Columbia. 2018, March. <http://www.bccdc.ca/health-professionals/data-reports/overdose-response-reports>

[7]D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, et al. Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence: A Randomized Clinical Trial. JAMA 2015;313(16):1636-44.

[8]Teruya C, Schwartz R, Mitchell SG, Hasson AL, Thomas C, Buoncristiani SH, et al. Patient Perspectives on Buprenorphine/Naloxone: A Qualitative Study of Retention During the Starting Treatment with Agonist Replacement Therapies Study. J Psychoactive Drugs 2014;46(5):412-26.

[9]DeFlavio JR, Rolin SA, Nordstrom BR, Kazal LA Jr. Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. Rural Remote Health 2015;15:2019.

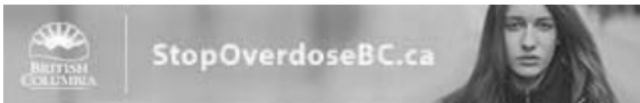
[10] Hammig R, Kemter A, Strasser J, von Bardeldeben U, Gugger B, Walter M. Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: The Bernese method. Subst Abuse Rehabil 2016;7:99-105.

[11] Klaire S, Zivanovic R, Barbic DP, Sandhu R, Mathew N, Azar P. Rapid Micro-Induction of Buprenorphine/Naloxone for Opioid Use Disorder in an Inpatient Setting: A Case Series. Am J Addict 2019;28(4):262-5.

Take care,  
Carolyn

**Carolyn Davison** | Director | Overdose Evaluation & Monitoring | Overdose Emergency Response Centre | Strategic Priorities & Initiatives Division | Ministry of Mental Health and Addictions | PO Box 9672 Stn Prov Govt, Victoria, BC, V8W 9P1 | ph: 250-952-3674 c: 250-893-2330 | [carolyn.davison@gov.bc.ca](mailto:carolyn.davison@gov.bc.ca)

Office Location:  
1515 Blanshard St., 1<sup>st</sup> Floor



Page 025 of 193 to/à Page 026 of 193

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s.13 ; s.17

## Substance Use and Addictions Program (SUAP) Application for Funding (Revised July 2019)

Complete the template in full and submit a signed copy to: [hc.SUAP-PUDS.sc@canada.ca](mailto:hc.SUAP-PUDS.sc@canada.ca)

The SUAP **Guidelines for Applicants** is available at:

<https://www.canada.ca/en/health-canada/services/publications/healthy-living/substance-use-addictions-program-call-for-proposals-guidelines-applicants.html#a15>

Health Canada collects information for the purpose of evaluating funding applications for grants and/or contributions. The information contained in the Application for Funding may be accessible under the provisions of the *Access to Information Act*. All personal information will be protected in accordance with the *Privacy Act*.

s.17

Page 028 of 193 to/à Page 036 of 193

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s.17

Page 037 of 193

Withheld pursuant to/removed as

s.17 ; s.13



Page 038 of 193 to/à Page 062 of 193

Withheld pursuant to/removed as

s.17

**From:** [Casanova, Tamara MMHA:EX](#)  
**To:** [Walsh, Taryn MMHA:EX](#)  
**Cc:** [Mayhew, Neilane MMHA:EX](#)  
**Subject:** Final Minister signed letter of support SUAP proposal  
**Date:** September 25, 2019 4:04:03 PM  
**Attachments:** [Letter of Support SAFER SUAP proposal - Signed - 2019-09-25.pdf](#)  
**Importance:** High

---

Hi Taryn,

Attached is the final, minister signed letter. I understand this will be include in a package that you are leading.

With thanks,

**Tamara Casanova**

Director, Executive Operations, Office of the Deputy Minister  
Ministry of Mental Health and Addictions  
250-952-1125 | [tamara.casanova@gov.bc.ca](mailto:tamara.casanova@gov.bc.ca)



September 17, 2019

Dr. Bonnie Henry,  
BC Provincial Health Officer.  
Ministry of Health  
PO BOX 9050 STN PROV GOVT  
Victoria, British Columbia V8W 9E2

Dear Dr Henry,

s.13; s.17

**Pilot Proposal**

Several months ago, we had a brief and general conversation about the opportunity for a BC pilot project

s.13; s.17

s.13; s.17

As we discussed, the BCPhA has little or no standing to make a direct request of the Federal government for the needed exemption to conduct a pilot project. But the Province of BC, through you and the Minister of Mental Health and Addictions could do so.

We have done some work on determining the best focus for a proposed pilot project. In consultation with prescribers and those directly charged with responding to the opioid epidemic we have identified four communities which are in high need of increasing access to OAT. We have prepared a general briefing document that lays out our proposal for the pilot. I am hopeful you will agree this project would add an important element to the provincial strategy to address the overdose crisis. I would welcome the opportunity to review our recommendation with you and determine how best to proceed.

Sincerely,

A handwritten signature in cursive script, reading "Geraldine Vance".

Geraldine Vance  
CEO

The number of British Columbians suffering from opioid use disorder (OUD) and dying from contamination of the illicit drug supply has remained at unprecedented levels since BC's provincial health officer declared a public health emergency in response to this epidemic on April 14, 2016. While Provincial harm reduction initiatives like the Take Home Naloxone program, overdose prevention sites and increased numbers of prescribers of opioid agonist treatment (OAT) are averting a significant number of overdose deaths, more can be done to help patients access life-saving treatments.

## 2. Pharmacists – Filling The Gaps

There are more than 1,100 community pharmacies that dispense OAT across the Province. Pharmacists see many of their patients treated with OAT on a daily basis and at hours outside of typical clinic hours. They regularly assess adherence, efficacy, adverse effects and understand the practical challenges that patients experience in seeking treatment as a result of this frequent contact. These frequent interactions also contribute to building trusting long-term therapeutic relationships with patients.

s.13; s.17

### 3. Communities in Need

There are a number of communities around the province that could benefit s.13; s.17  
 s.13; s.17 . Four communities that may be suitable for a pilot are described  
 here:

s.13; s.17

s.13; s.17

#### **4. Pilot Objectives**

s.13; s.17

#### **5. Collaboration**

s.13; s.17

## 6. Pharmacist Training

s.13; s.17

## 7. Patient Assessment

s.13; s.17

s.13; s.17

## 9. Patient Education

s.13; s.17

## 10. Next Steps

This draft proposal is designed to create the basis for a discussion with the BC Government on moving forward with s.13; s.17 demonstration pilot. Once the approach, content, scale and timelines are generally agreed to, the BCPhA will produce a more detailed project plan and budget for development and implementation of the proposed project.

## 11. BCPhA's Experience in Pilot and Training

For many years BCPhA has been responsible for significant large-scale pharmacist education and skills training programs. These programs have been transformational to the practice including, administration of injections training, regulatory compliance training, prescription adaptation training and most recently the Opioid Agonist Treatment Compliance and Management Program for Pharmacy. In addition, BCPhA has also lead several innovative demonstration pilots including the BC Medication Management Project and Genomics for Precision Drug Therapy in the Community Pharmacy Phases 1 and 2. BCPhA has the experience and its members are prepared to support a s.13; s.17

s.13; s.17





September 26, 2019

1145117

Substance Use and Addictions Program (SUAP)  
Health Canada  
Address Locator 0900C2  
Ottawa ON K1A 0K9

Re: Letter of Support for Vancouver Coastal Health's SUAP Application entitled "Safer Alternatives For Emergency Response (SAFER) Initiative"

On behalf of the Province of British Columbia, I am pleased to express my support for the SUAP application submitted by Vancouver Coastal Health (VCH) to pilot the expansion of existing continuum of addiction care to include a low-barrier and flexible safer supply of pharmaceutical alternatives to toxic street drugs, while connecting people to wrap around care.

As you are aware, British Columbia is in the midst of an opioid overdose public health emergency. In British Columbia, our coordinated response to the overdose crisis has focused on four key pillars: Prevention; Harm Reduction; Treatment and Other Support Services and Enforcement. Our response has been largely characterized by the expansion of harm reduction services such as naloxone distribution, overdose prevention and safe drug consumption sites, and drug checking services. Additionally, improving uptake of, and access to, evidence-based treatments for opioid use disorder (OUD), namely oral and injectable opioid agonist treatment (OAT), have been prioritized across the province.

Our overdose response efforts have yielded significant results. Specifically, research has demonstrated that the combined impact of naloxone distribution, supervised consumption services and overdose prevention services and OAT have averted more than 3000 additional overdose deaths. However, despite significant efforts, the number of people who died of an overdose essentially remained unchanged from 2017 to 2018, with a small decline expected in 2019. As well, the total numbers of non-fatal overdoses remains high. Accordingly, we know that more must be done to expand the continuum of care for people who use drugs.

As shown by point-in-time data from December 2018, it is estimated that there are nearly 114,000 people in BC living with OUD. As noted in the proposal, there is an additional population identified which adds to the 114,000 estimate of potential patients who could benefit from additional substance use health services. Using a Vancouver Coastal Health (VCH) chart review, more than half of those who died from opioid overdose in 2018 used substances other than opioids on a daily basis and opioids only intermittently, and therefore may not have met the criteria for OAT. Many of these would also likely benefit from access to addiction treatment for other substance addictions that likely drive their use of illegal opioids and increase overdose risk (e.g. stimulant addiction that drives opioid addiction).

...2

Currently only 65,000 individuals have been formally diagnosed with OUD and only one-third of people diagnosed are receiving OAT at around 22,000 individuals. Further, research shows us that only half of people with OUD who had been prescribed OAT remained engaged in treatment for at least 12 months.

Based on the challenges of providing support to this patient population, the general growth of service development has been to continue to expand service options for OAT and continue to reduce barriers to accessing pharmaceutical-grade opioid medications. The SAFER Initiative offers an innovative approach, that will be compliant with the existing regulatory framework for controlled substances, that aims to pilot the expansion of the existing continuum of addiction care to provide low-barrier access to pharmaceutical-grade opioid medications while also supporting access to the wider array of wrap-around substance use services, including recovery services, public health and social services.

It focuses on both populations noted above, those living with opioid addiction and those with a substance use disorder who are using illegal opioids, where in both case whose treatment has not yet been optimized despite access to evidence-based addiction treatment.

We support the intent of the proposal to try to save more lives through a lower barrier/easier access to pharmaceutical-grade opioid medications within the current legal framework. On this basis, we offer support for the proposal while noting some specific requirements which will need to be addressed before a full endorsement. The Ministry of Mental Health and Addictions (MMHA) and the Ministry of Health (Health) will work with the proponents to address these requirements over the balance of the fall and winter in advance of a final decision from Health Canada on which proposals they would recommend for funding. Specifically, our noted requirements are:

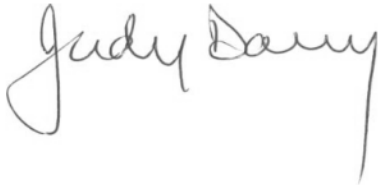
s.13

Notwithstanding these requirements, I would like to strongly commend the efforts of the regional health authority (VCH) and health system partners (Portland Hotel Society and BC Centre on Substance Use) in their efforts to innovate better ways to support and protect these patients. Moreover, the partner organizations on this grant have a demonstrated history of providing community-based health services to people who use drugs, engaging with and supporting people with lived experience, and conducting innovative research in the field of substance use.

...4

Once again, on behalf of the Ministry of Mental Health and Addictions, I am pleased to offer my support to VCH for the SAFER Initiative. Please contact me if further clarification is required.

Sincerely,

A handwritten signature in cursive script, reading "Judy Darcy". The signature is written in dark ink and is positioned above the printed name and title.

Judy Darcy  
Minister

pc: Adrian Dix, Minister, Ministry of Health  
Stephen Brown, Deputy Minister, Ministry of Health  
Neilane Mayhew, Deputy Minister, Ministry of Mental Health and Addictions

## Yamashita, Ann MMHA:EX

---

**From:** MacKenzie, Jennifer E MMHA:EX  
**Sent:** November 19, 2019 10:07 AM  
**To:** Yamashita, Ann MMHA:EX  
**Subject:** FW: iOAT brief  
**Attachments:** Overview iOAT&TiOAT Funding - ETF, EA's and CIF.docx; Overview SUAP TiOAT Funding Proposal (FHA, IHA, IH).docx; 2019 09 19 - DRAFT iOAT Expansion DBN rv.docx

Jennifer MacKenzie, RN, BScN  
Clinical Lead, Overdose Emergency Response Centre (OERC)  
Ministry of Mental Health and Addictions  
201-828 W 8<sup>th</sup> Avenue, Vancouver, BC  
C:778-988-9276  
E:Jennifer.e.mackenzie@gov.bc.ca

"I acknowledge with gratitude that I live and work on the unceded homelands of the x<sup>w</sup>məθk<sup>w</sup>əyəm (Musqueam), Skwxwú7mesh Úxwumixw (Squamish), and səliłwətaʔł (Tsleil Waututh) First Nations"

---

**From:** Yee, Arthur MMHA:EX  
**Sent:** September 23, 2019 10:19 AM  
**To:** Mayhew, Neilane MMHA:EX  
**Cc:** Patterson, Justine A MMHA:EX ; MacKenzie, Jennifer E MMHA:EX ; Walsh, Taryn MMHA:EX  
**Subject:** RE: iOAT brief

Good morning Neilane,

Just reaching out to provide some background on the iOAT/TiOAT briefing scheduled for 4pm today.

Purpose of this briefing is to provide a heads-up on a briefing note that is in process of being signed-off by Taryn and Dara from MMHA, before it goes back to MoH.

For your reference, am sending through most current draft version of the iOAT/TiOAT briefing note (may be further updated throughout course of today), along with some additional discussion materials. Jenn MacKenzie and Justine Patterson will be leading this briefing.

Regards,  
Art

**Arthur Yee**  
Director, Overdose Emergency Response Centre  
Ministry of Mental Health and Addictions  
201-828 W 8<sup>th</sup> Ave, Vancouver, BC  
Cell: 604.202.2049  
Email: [arthur.yee@gov.bc.ca](mailto:arthur.yee@gov.bc.ca)

-----Original Appointment-----

**From:** Walsh, Taryn MMHA:EX

**Sent:** September 23, 2019 9:35 AM

**To:** Walsh, Taryn MMHA:EX; Mayhew, Neilane MMHA:EX; Patterson, Justine A MMHA:EX; Yee, Arthur MMHA:EX; MacKenzie, Jennifer E MMHA:EX

**Subject:** iOAT brief

**When:** September 23, 2019 4:00 PM-4:30 PM (UTC-08:00) Pacific Time (US & Canada).

**Where:** TCT

---

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[Forgot your dial-in PIN?](#) | [Help](#)

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s.13 ; s.17

**MINISTRY OF HEALTH  
DECISION BRIEFING NOTE**

**Cliff #1143690**

**PREPARED FOR:** Teri Collins, Assistant Deputy Minister and Taryn Walsh, Assistant Deputy Minister - **FOR DECISION**

**TITLE:** 2019/20 iOAT expansion funding allocations

**PURPOSE:** To recommend health authority iOAT expansion allocations for approval

**BACKGROUND:**

The Ministries of Health (MoH) and Mental Health and Addictions (MMHA) and the Overdose Emergency Response Centre (OERC) have been expanding access to injectable opioid agonist treatment (iOAT) across the Province since April 2017 in response to the public health emergency. Current iOAT services and expansion projects draw from three funding sources:

1. Provincial Overdose Funding
2. Federal ~~Early Actions~~ MHA Funding
3. Emergency Treatment Fund (ETF)

In addition to the \$3.93M provided as base budget to the MoH for iOAT expansion in Budget Update 2017, s.17

s.17 from two of the funding sources listed above—Federal ~~Early Actions~~ MHA (\$8M) and ETF (\$2M)—s.17

s.17 There is also \$12M and \$16M allocated to iOAT expansion from the federal MHSU funding in 2020/21 and 2021/22 respectively.

In the first two phases of implementation and expansion, iOAT services opened in select clinical settings across the Province. By August 2019, iOAT was available in several communities in most health authorities (Northern Health being the only exception). Clinics are now in all high-need communities as determined by overdose surveillance data. These communities are: Surrey, Kelowna, Victoria and multiple Vancouver locations.

In July 2019, RHAs were invited to submit proposals to further expand iOAT services—including to begin or expand tablet iOAT (TiOAT) pilot services. Priorities for expansion are to: 1) increase engagement and retention, 2) innovate, and 3) evaluate. RHAs were encouraged to submit funding ideas to:

- Increase the reach, sustainability or effectiveness of current iOAT programs. In this case, Health Authorities were asked for details on funding required to maintain *current* iOAT programs.
- Pilot *new*, low-barrier programs or novel iOAT engagement/retention strategies supported by developmental evaluation plans.



- Implement or strengthen real-time *evaluation and/or quality improvement* practices.

RHAs were provided with a template, and separate funding ranges for iOAT and TiOAT to guide their submissions. Funding ranges varied by RHA and were determined by epidemiologic data (absolute overdose deaths and mortality rate), discussions with RHAs, current capacity/readiness to expand, and ability of each RHA to utilize the funding prior to end of 2019/20 fiscal.

## **DISCUSSION:**

s.13; s.17

## **OPTIONS:**

s.13; s.17

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<sup>1</sup> Note: Minor budget adjustments may be required as RHAs finalize plans and drug costs. Budget surplus provides a contingency for these adjustments (see “Financial Implications” section).

s.13; s.17

**FINANCIAL IMPLICATIONS:**

s.13; s.17

**RECOMMENDATION:**

s.13; s.17

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Approved/Not Approved  
Taryn Walsh  
ADM, Strategic Planning & Initiatives  
Ministry of Mental Health and Addictions

---

Date Signed

---

Approved/Not Approved  
Teri Collins  
ADM, Specialized Services

---

Date Signed

---

**Program ADM/Division:** MHSU Branch, Ministry of Health

**Telephone:**  
**Program Contact (for content):**  
**Drafter:**  
**Date:**  
**File Name with Path:**

Page 081 of 193

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s.17

Page 082 of 193

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s.13 ; s.17

## Yamashita, Ann MMHA:EX

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**From:** Patterson, Justine A MMHA:EX  
**Sent:** November 18, 2019 12:29 PM  
**To:** Yamashita, Ann MMHA:EX  
**Subject:** FW: FYI re: Draft iOAT DBN

---

**From:** Patterson, Justine A MMHA:EX  
**Sent:** September 5, 2019 2:50 PM  
**To:** Gauf, Eric HLTH:EX ; Tupper, Kenneth HLTH:EX ; Halsall, Elaine HLTH:EX ; Clow, Holly HLTH:EX ; MacKenzie, Jennifer E MMHA:EX  
**Cc:** Gudmunson, Kathryn HLTH:EX ; Emslie, Margaret J HLTH:EX ; Wan, Beverly HLTH:EX  
**Subject:** RE: FYI re: Draft iOAT DBN

Seems like the group has spoken.....however.....

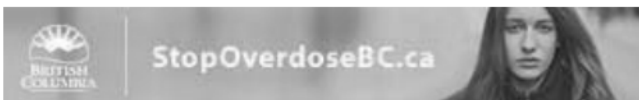
s.13; s.17

Kind Regards,

**Justine Patterson**

Executive Director, Overdose Emergency Response Centre  
Ministry of Mental Health and Addictions  
201-828 W 8<sup>th</sup> Ave, Vancouver, BC  
s.17 (cell)

*On the Unceded Territory of the Coast Salish*



---

**From:** Gauf, Eric HLTH:EX

**Sent:** September 5, 2019 2:26 PM

**To:** Tupper, Kenneth HLTH:EX <[Kenneth.Tupper@gov.bc.ca](mailto:Kenneth.Tupper@gov.bc.ca)>; Halsall, Elaine HLTH:EX <[Elaine.Halsall@gov.bc.ca](mailto:Elaine.Halsall@gov.bc.ca)>; Clow, Holly HLTH:EX <[Holly.Clow@gov.bc.ca](mailto:Holly.Clow@gov.bc.ca)>; Patterson, Justine A MMHA:EX <[Justine.Patterson@gov.bc.ca](mailto:Justine.Patterson@gov.bc.ca)>; MacKenzie, Jennifer E MMHA:EX <[Jennifer.E.MacKenzie@gov.bc.ca](mailto:Jennifer.E.MacKenzie@gov.bc.ca)>

**Cc:** Gudmunson, Kathryn HLTH:EX <[Kathryn.Gudmunson@gov.bc.ca](mailto:Kathryn.Gudmunson@gov.bc.ca)>; Emslie, Margaret J HLTH:EX <[Margaret.Emslie@gov.bc.ca](mailto:Margaret.Emslie@gov.bc.ca)>; Wan, Beverly HLTH:EX <[Beverly.Wan@gov.bc.ca](mailto:Beverly.Wan@gov.bc.ca)>

**Subject:** RE: FYI re: Draft iOAT DBN

I agree with Ken and Elaine

s.17; s.13

s.17; s.13

Eric

---

**From:** Tupper, Kenneth HLTH:EX

**Sent:** September 5, 2019 1:37 PM

**To:** Halsall, Elaine HLTH:EX <[Elaine.Halsall@gov.bc.ca](mailto:Elaine.Halsall@gov.bc.ca)>; Clow, Holly HLTH:EX <[Holly.Clow@gov.bc.ca](mailto:Holly.Clow@gov.bc.ca)>; Patterson, Justine A MMHA:EX <[Justine.Patterson@gov.bc.ca](mailto:Justine.Patterson@gov.bc.ca)>; MacKenzie, Jennifer E MMHA:EX <[Jennifer.E.MacKenzie@gov.bc.ca](mailto:Jennifer.E.MacKenzie@gov.bc.ca)>

**Cc:** Gauf, Eric HLTH:EX <[Eric.Gauf@gov.bc.ca](mailto:Eric.Gauf@gov.bc.ca)>; Gudmunson, Kathryn HLTH:EX <[Kathryn.Gudmunson@gov.bc.ca](mailto:Kathryn.Gudmunson@gov.bc.ca)>; Emslie, Margaret J HLTH:EX <[Margaret.Emslie@gov.bc.ca](mailto:Margaret.Emslie@gov.bc.ca)>; Wan, Beverly HLTH:EX <[Beverly.Wan@gov.bc.ca](mailto:Beverly.Wan@gov.bc.ca)>

**Subject:** RE: FYI re: Draft iOAT DBN

Hi all

I'm definitely coming in late in the game here, but a few observations: 1) This seems like a pretty fully baked cake, with obviously a big amount of work that's gone into it,

s.17; s.13

s.17; s.13

My \$0.02, for what they're worth

Ken

---

**From:** Halsall, Elaine HLTH:EX

**Sent:** September 5, 2019 1:09 PM

**To:** Clow, Holly HLTH:EX <[Holly.Clow@gov.bc.ca](mailto:Holly.Clow@gov.bc.ca)>; Patterson, Justine A MMHA:EX <[Justine.Patterson@gov.bc.ca](mailto:Justine.Patterson@gov.bc.ca)>; MacKenzie, Jennifer E MMHA:EX <[Jennifer.E.MacKenzie@gov.bc.ca](mailto:Jennifer.E.MacKenzie@gov.bc.ca)>

**Cc:** Gauf, Eric HLTH:EX <[Eric.Gauf@gov.bc.ca](mailto:Eric.Gauf@gov.bc.ca)>; Gudmunson, Kathryn HLTH:EX <[Kathryn.Gudmunson@gov.bc.ca](mailto:Kathryn.Gudmunson@gov.bc.ca)>; Tupper, Kenneth HLTH:EX <[Kenneth.Tupper@gov.bc.ca](mailto:Kenneth.Tupper@gov.bc.ca)>; Emslie, Margaret J HLTH:EX <[Margaret.Emslie@gov.bc.ca](mailto:Margaret.Emslie@gov.bc.ca)>; Wan, Beverly HLTH:EX <[Beverly.Wan@gov.bc.ca](mailto:Beverly.Wan@gov.bc.ca)>

**Subject:** Re: FYI re: Draft iOAT DBN

Hello

s.17; s.13

s.13; s.17

Elaine

---

**From:** Clow, Holly HLTH:EX  
**Sent:** September-05-19 12:55 PM  
**To:** Patterson, Justine A MMHA:EX; MacKenzie, Jennifer E MMHA:EX  
**Cc:** Halsall, Elaine HLTH:EX; Gauf, Eric HLTH:EX; Gudmunson, Kathryn HLTH:EX; Tupper, Kenneth HLTH:EX; Emslie, Margaret J HLTH:EX; Wan, Beverly HLTH:EX  
**Subject:** RE: FYI re: Draft iOAT DBN

Thanks Justine,

s.13; s.17

Elaine—thoughts?

Holly Clow  
A/Manager, Mental Health and Substance Use  
Specialized Services Division | Ministry of Health  
1515 Blanshard St., Victoria BC  
Traditional homelands of the Lekwungen speaking peoples of Esquimalt and Songhees First Nations  
(778) 698-1579  
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**From:** Patterson, Justine A MMHA:EX  
**Sent:** September 5, 2019 12:44 PM  
**To:** Clow, Holly HLTH:EX <[Holly.Clow@gov.bc.ca](mailto:Holly.Clow@gov.bc.ca)>; MacKenzie, Jennifer E MMHA:EX <[Jennifer.E.MacKenzie@gov.bc.ca](mailto:Jennifer.E.MacKenzie@gov.bc.ca)>  
**Cc:** Halsall, Elaine HLTH:EX <[Elaine.Halsall@gov.bc.ca](mailto:Elaine.Halsall@gov.bc.ca)>; Gauf, Eric HLTH:EX <[Eric.Gauf@gov.bc.ca](mailto:Eric.Gauf@gov.bc.ca)>; Gudmunson, Kathryn HLTH:EX <[Kathryn.Gudmunson@gov.bc.ca](mailto:Kathryn.Gudmunson@gov.bc.ca)>; Tupper, Kenneth HLTH:EX <[Kenneth.Tupper@gov.bc.ca](mailto:Kenneth.Tupper@gov.bc.ca)>; Emslie, Margaret J HLTH:EX <[Margaret.Emslie@gov.bc.ca](mailto:Margaret.Emslie@gov.bc.ca)>  
**Subject:** RE: FYI re: Draft iOAT DBN

Hi All,

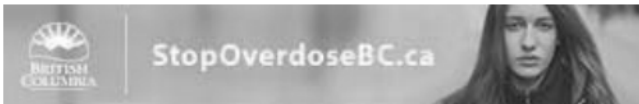


Kind Regards,

**Justine Patterson**

Executive Director, Overdose Emergency Response Centre  
Ministry of Mental Health and Addictions  
201-828 W 8<sup>th</sup> Ave, Vancouver, BC  
604.341.2407 (cell)

*On the Unceded Territory of the Coast Salish*



---

**From:** Clow, Holly HLTH:EX

**Sent:** September 5, 2019 12:14 PM

**To:** Patterson, Justine A MMHA:EX <[Justine.Patterson@gov.bc.ca](mailto:Justine.Patterson@gov.bc.ca)>; MacKenzie, Jennifer E MMHA:EX <[Jennifer.E.MacKenzie@gov.bc.ca](mailto:Jennifer.E.MacKenzie@gov.bc.ca)>

**Cc:** Wan, Beverly HLTH:EX <[Beverly.Wan@gov.bc.ca](mailto:Beverly.Wan@gov.bc.ca)>; Halsall, Elaine HLTH:EX <[Elaine.Halsall@gov.bc.ca](mailto:Elaine.Halsall@gov.bc.ca)>; Gauf, Eric HLTH:EX <[Eric.Gauf@gov.bc.ca](mailto:Eric.Gauf@gov.bc.ca)>; Reyes, Aureleo P HLTH:EX <[Aureleo.Reyes@gov.bc.ca](mailto:Aureleo.Reyes@gov.bc.ca)>; Mei, Cindy (Peiyu) HLTH:EX <[Cindy.Mei@gov.bc.ca](mailto:Cindy.Mei@gov.bc.ca)>; Gudmunson, Kathryn HLTH:EX <[Kathryn.Gudmunson@gov.bc.ca](mailto:Kathryn.Gudmunson@gov.bc.ca)>; Tupper, Kenneth HLTH:EX <[Kenneth.Tupper@gov.bc.ca](mailto:Kenneth.Tupper@gov.bc.ca)>; Wilson, Leila HLTH:EX <[Leila.Wilson@gov.bc.ca](mailto:Leila.Wilson@gov.bc.ca)>

**Subject:** FYI re: Draft iOAT DBN

Hi there,

Ross has review this BN and it will make it's way into e-apps today.

**Justine--can you flag this for Taryn?** If she approves soon, then I believe Ross can approve this week on behalf of Teri before the finance folks.

Holly Clow

A/Manager, Mental Health and Substance Use  
Specialized Services Division | Ministry of Health  
1515 Blanshard St., Victoria BC

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-----Original Message-----

From: Clow, Holly HLTH:EX

Sent: September 5, 2019 12:00 PM

To: Hayward, Ross HLTH:EX <Ross.Hayward@gov.bc.ca>; Wilson, Leila HLTH:EX <Leila.Wilson@gov.bc.ca>

Cc: Tupper, Kenneth HLTH:EX <Kenneth.Tupper@gov.bc.ca>; Halsall, Elaine HLTH:EX <Elaine.Halsall@gov.bc.ca>

Subject: RE: FOR REVIEW/APPROVAL: Draft iOAT DBN

Hi Ross,

s.13; s.17

s.13; s.17 . I clarified this in the attached BN (see highlighted change).

Holly Clow

A/Manager, Mental Health and Substance Use Specialized Services Division | Ministry of Health

1515 Blanshard St., Victoria BC

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-----Original Message-----

From: Hayward, Ross HLTH:EX

Sent: September 5, 2019 11:28 AM

To: Wilson, Leila HLTH:EX <Leila.Wilson@gov.bc.ca>

Cc: Clow, Holly HLTH:EX <Holly.Clow@gov.bc.ca>; Tupper, Kenneth HLTH:EX <Kenneth.Tupper@gov.bc.ca>

Subject: RE: FOR REVIEW/APPROVAL: Draft iOAT DBN

Thanks Meg and team.

s.13; s.17

s.13; s.17

Thanks

-----Original Message-----

From: Wilson, Leila HLTH:EX

Sent: September 5, 2019 8:35 AM

To: Hayward, Ross HLTH:EX <Ross.Hayward@gov.bc.ca>

Cc: Clow, Holly HLTH:EX <Holly.Clow@gov.bc.ca>; Tupper, Kenneth HLTH:EX <Kenneth.Tupper@gov.bc.ca>

Subject: FW: FOR REVIEW/APPROVAL: Draft iOAT DBN

Morning Ross,

Latest version for your review/approval 🙏

Kind regards,

Leila Wilson

Executive Administrative Assistant to Ross Hayward - Executive Director Mental Health & Substance Use, Ministry of Health

P: 250-952-3124 | email: leila.wilson@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 phone or e-mail the sender immediately and delete the message.

-----Original Message-----

From: Clow, Holly HLTH:EX

Sent: September 5, 2019 6:10 AM

To: Wilson, Leila HLTH:EX <Leila.Wilson@gov.bc.ca>

Cc: Tupper, Kenneth HLTH:EX <Kenneth.Tupper@gov.bc.ca>

Subject: FW: FOR REVIEW/APPROVAL: Draft iOAT DBN

Morning Leila!

This is the latest for Ross's review :)

-Holly

---

From: Clow, Holly HLTH:EX

Sent: September-04-19 5:19 PM

To: Tupper, Kenneth HLTH:EX; Hayward, Ross HLTH:EX

Cc: Halsall, Elaine HLTH:EX; Gudmunson, Kathryn HLTH:EX; Wilson, Leila HLTH:EX

Subject: RE: FOR REVIEW/APPROVAL: Draft iOAT DBN

Perfection!

Thanks very much for the end of day review, Ken!

I have attached the version with all of your suggestions incorporated.

s.13

s.13

Thanks again—one step closer!

Holly Clow

A/Manager, Mental Health and Substance Use Specialized Services Division | Ministry of Health

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From: Tupper, Kenneth HLTH:EX

Sent: September 4, 2019 5:12 PM

To: Clow, Holly HLTH:EX <Holly.Clow@gov.bc.ca>; Hayward, Ross HLTH:EX <Ross.Hayward@gov.bc.ca>

Cc: Halsall, Elaine HLTH:EX <Elaine.Halsall@gov.bc.ca>; Gudmunson, Kathryn HLTH:EX <Kathryn.Gudmunson@gov.bc.ca>; Wilson, Leila HLTH:EX <Leila.Wilson@gov.bc.ca>  
Subject: RE: FOR REVIEW/APPROVAL: Draft iOAT DBN

Thanks for this Holly – I've reviewed and suggested some edits (mostly minor and not too substantive, as I don't have the deep background on this file that Meg did). I hope this is helpful – let me know if you have any questions or concerns.

Cheers  
Ken

From: Clow, Holly HLTH:EX  
Sent: September 4, 2019 4:00 PM  
To: Tupper, Kenneth HLTH:EX <Kenneth.Tupper@gov.bc.ca<mailto:Kenneth.Tupper@gov.bc.ca>>; Hayward, Ross HLTH:EX <Ross.Hayward@gov.bc.ca<mailto:Ross.Hayward@gov.bc.ca>>  
Cc: Halsall, Elaine HLTH:EX <Elaine.Halsall@gov.bc.ca<mailto:Elaine.Halsall@gov.bc.ca>>; Gudmunson, Kathryn HLTH:EX <Kathryn.Gudmunson@gov.bc.ca<mailto:Kathryn.Gudmunson@gov.bc.ca>>; Wilson, Leila HLTH:EX <Leila.Wilson@gov.bc.ca<mailto:Leila.Wilson@gov.bc.ca>>  
Subject: FOR REVIEW/APPROVAL: Draft iOAT DBN

Good afternoon Ken and Ross,

As discussed, attached is the iOAT expansion DBN for your initial review before it is uploaded into e-apps. It outlines the recommendations for funding per HA. Here are a few caveats/notes:

s.13; s.17

Our next steps (with timelines that may be a bit ambitious) are:

1. Ross and Ken to complete initial review
2. Holly to send to Justine, Jen, Bev, Eric and the rest of the review panel for review
3. Holly to work with admin to upload into e-apps
  - \* Taryn to review/approve (Justine/Jen to shepherd this through)
  - \* Teri (or Ross | s.22 to approve
  - \* MoH and MMHA finance to approve
4. Aureleo to communicate new funding to HA finance in writing, via e-mail to allow implementation to begin as soon as possible and ensure this is officially communicated later in the fall funding letters.

Thank you!

Holly Clow  
A/Manager, Mental Health and Substance Use Specialized Services Division | Ministry of Health  
1515 Blanshard St., Victoria BC  
Traditional homelands of the Lekwungen speaking peoples of Esquimalt and Songhees First Nations  
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## Yamashita, Ann MMHA:EX

---

**From:** Patterson, Justine A MMHA:EX  
**Sent:** November 18, 2019 12:30 PM  
**To:** Yamashita, Ann MMHA:EX  
**Subject:** FW: Pharmaceutical alternatives \_RRT Leads (002)  
**Attachments:** Pharmaceutical alternatives \_RRT Leads (002).docx

---

**From:** Patterson, Justine A MMHA:EX  
**Sent:** September 6, 2019 9:34 AM  
**To:** Emslie, Margaret J HLTH:EX ; Clow, Holly HLTH:EX ; Halsall, Elaine HLTH:EX ; Tupper, Kenneth HLTH:EX ; Gudmunson, Kathryn HLTH:EX  
**Cc:** Hayward, Ross HLTH:EX ; MacKenzie, Jennifer E MMHA:EX  
**Subject:** Pharmaceutical alternatives \_RRT Leads (002)

Hi All,

Please find attached an outline of pharmaceutical alternatives for an emergency response including rationale, approaches for a continuum of care and policy framework. This will be helpful information as we start discussing how we can support pharmaceutical alternatives while keeping within the existing regulatory and legislative framework.

We are moving into an evidence informed space and need to identify a clear plan to support these initiatives while adhering to policy framework and PHO recommendations, and working within the context of a public health emergency.

Given that we know the overdose death rates remain unacceptably high and the highest in Canada, and that overdose event rates and severity of events are increasing, taking the typical approach of pilot, evaluation and expansion is not ideal. We also know that anoxic brain injury and other poor health outcomes are emerging as a result of repeated and complex overdose events, which will create significant downstream health system impacts. We need to scale and evaluate simultaneously to save lives, and ensure appropriate provincial and HA oversight and an independent evaluation that can support pivoting our response if required and addressing any unintended health consequences.

I suggest a phased approach to TiOAT expansion:

s.13

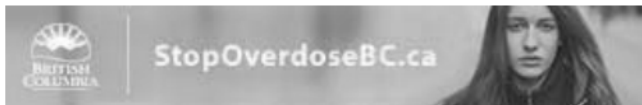
I look forward to discussing this further.

Kind Regards,

**Justine Patterson**  
Executive Director, Overdose Emergency Response Centre  
Ministry of Mental Health and Addictions

201-828 W 8<sup>th</sup> Ave, Vancouver, BC  
604.341.2407 (cell)

*On the Unceded Territory of the Coast Salish*

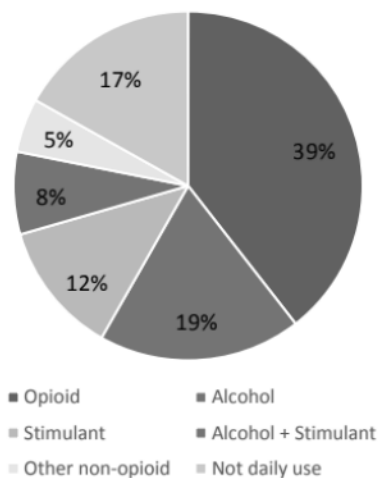


## Prescribed Pharmaceutical Alternatives for an Emergency Response

### Background

- We support increasing access to legal, prescription alternatives to the toxic drug supply that can be provided under medical supervision to save lives.
- Since early 2019, illicit drug deaths in BC have decreased as directly compare to the extremely high mortality experienced in 2017 and 2018, however drug-related mortality remains extremely high relative to longer-term historical trends, and remains the highest in Canada
- Trends in paramedic-attended overdose events, largely non-fatal, are increasing.
- Trends in the severity of patient presentation upon paramedic arrival is extremely high and not declining.
- Initiatives that support access to pharmaceutical alternatives are built on the strong evidence available for the effectiveness of reducing harm through the provision of regulated pharmaceutical-grade opioids to people who use illegal opioids under the supervision of health care providers (eg. OAT, iOAT, emerging evidence from TiOAT).
- Pharmaceutical alternatives reduce harms, reduce the risk of overdose/poisoning by separating people who use illegal drugs from the illegal market, improve social functioning and social integration, increase HIV treatment adherence and can reduce hepatitis C infection.
- At least 55,470 people are diagnosed with OUD (many more undiagnosed). Existing system is not equipped to treat all those who require it.
- VCH Chart Review of opioid deaths in 2017: 61% of people who died were intermittent opioid users and therefore would not be eligible for existing treatment programs (OAT and iOAT). Pharmaceutical alternatives can separate this high risk, underserved population from the illicit drug supply.

Pattern of Daily Drug Use (261 charts)





- OUD is a chronic relapsing condition. Pharmaceutical alternatives create a safety net for those who traditional treatment methods have been unsuccessful.
- Support for pharmaceutical alternatives are echoed elsewhere: Provincial Health Officer, addiction and public health physicians, Chief Medical Health Officer Dr Patty Dally (2019 report), City of Vancouver Task Force, the Federal government (Stream II: Increasing access to pharmaceutical grade medications funding call), Vancouver Police Department (2017 position paper), the BC Overdose Action Exchanges (2016, 2017 and 2018 reports), Community Action Teams, BCCDC and BCCSU.

#### **Approaches for a Continuum of Care (\*language aligns with Health Canada)**

- There is a continuum of care for addressing social and health concerns related to the use of substances that ranges from harm reduction approaches to addiction treatment approaches, and pharmaceutical alternative programs exist along this continuum.
- Similarly, pharmaceutical alternatives within the current regulatory and legislative frameworks exist along a continuum, anchored at one end by programs designed with as few barriers as possible (e.g., flexible eligibility requirements, unobserved dosing), and highly-clinical models of opioid agonist treatment on the other end (e.g., multiple witnessed daily doses, illegal drug abstinence).
- We are exploring pharmaceutical alternative programs that will build on medical models that require prescriptions and a degree of monitoring and care from authorized health professionals and that operate within the parameters set by the current legislation and regulations.

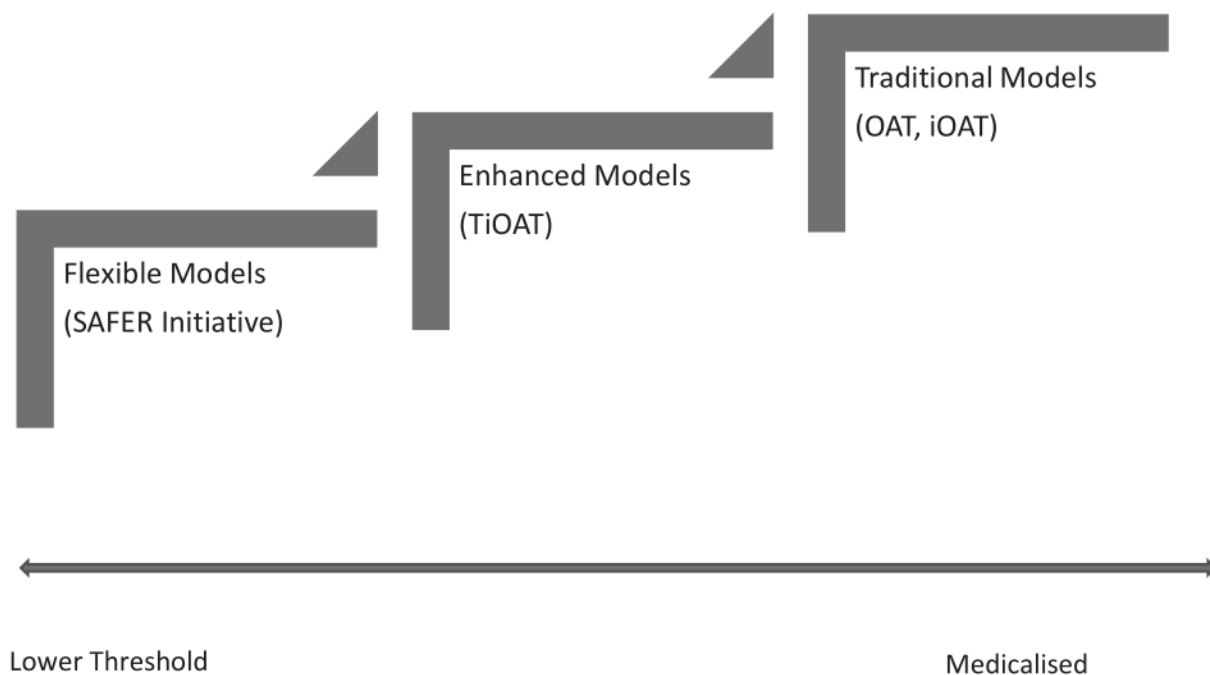


Figure 1: Approaches to pharmaceutical alternatives permissible within current regulatory and legislative framework.

### TiOAT

- In January 2019, the PHS Community Services Society launched a pilot program at the Molson OPS in Vancouver using hydromorphone tablets as part of the iOAT continuum of care. This option is available for people who have not benefitted from traditional OAT and iOAT programs, who are at a very high risk of overdose and have experienced multiple overdose events. Patients are also co-prescribed OAT and are supported to move along the continuum of care to meet their clinical needs, with a goal to eliminate illegal drug use and transition to oral treatment.
- Patients take hydromorphone tablets either orally or crushed for injection under medical supervision.
- The pilot has been successful in engaging and retaining patients, reaching full capacity by March 2, 2019, with a retention rate of 90%. Preliminary results from the pilot (n=62) demonstrate that since starting the program, no patients have had an overdose event, reported reduced drug use, increased engagement with primary care and OAT induction and maintenance. Preliminary findings indicate that this model is a cost-effective way of engaging a high-risk population in treatment, saving lives, and engaging patients in care (\$750,000/100 patients)
- Phase 1 planning is underway to increase patient capacity at the existing site and to expand to two additional sites in Vancouver and the Interior.

- Fraser Health, Vancouver Coastal Health, Interior Health and Island Health are seeking provincial scale up beyond phase 1 expansion plans of TiOAT. This could be leveraged through Stream II SUAP funding.

#### **SAFER Initiative (Safer Access For Emergency Response)**

- Stream II SUAP Funding proposal
- Health Canada requires:
  - Linkages to provincial health systems, including health authorities, regulatory bodies, and formal commitment from and access to necessary health professionals.
  - Appropriate prescriber/health care provider oversight
  - Ethics review
  - Independent, third party evaluation
- Two implementation sites: Vancouver Coastal Health and Island Health (one model, two SUAP applications)
- Interdisciplinary care management oversight, including peer assessment and navigation, nursing assessment, and physician oversight.
- All medications are prescribed.
- For high risk individuals with both OUD and non-OUD (substance use disorder with intermittent opioid use to address the high-risk population identified in the VCH chart review)
- Observed and take-home dosing (same process for methadone)
- No cost to provincial government for at least 4 years (Health Canada SUAP applications \$1.5M/year per site up to 4 years of funding)

#### **Policy Framework for Prescribed Pharmaceutical Alternatives**

- Low barrier access within current regulatory and legislative framework
- Requires pilot testing and evaluation to develop an evidence base
- Harm reduction and public health informed approach
- Adhere to the five principles outlined by the BC Provincial Health Officer
  1. Include people with lived experience and seek to hear from those most affected.
  2. Projects should be linked to and supported by health authority public health, substance use, and primary care units and have government support and oversight.
  3. Projects should be subject to an independent health care and research ethical reviews.
  4. Projects should include an independent evaluation process that follows an ethics-approved research protocol.
  5. Public health and health care strategies to reduce community and population wide rates of addiction should be implemented concurrently.

## Yamashita, Ann MMHA:EX

---

**From:** Patterson, Justine A MMHA:EX  
**Sent:** November 18, 2019 12:30 PM  
**To:** Yamashita, Ann MMHA:EX  
**Subject:** FW: Pharmaceutical alternatives \_RRT Leads (002)

---

**From:** Patterson, Justine A MMHA:EX  
**Sent:** September 6, 2019 11:38 AM  
**To:** Tupper, Kenneth HLTH:EX ; Emslie, Margaret J HLTH:EX ; Clow, Holly HLTH:EX ; Halsall, Elaine HLTH:EX ; Gudmunson, Kathryn HLTH:EX  
**Cc:** Hayward, Ross HLTH:EX ; MacKenzie, Jennifer E MMHA:EX  
**Subject:** RE: Pharmaceutical alternatives \_RRT Leads (002)

Just to clarify, there is no other context for this document other than keeping everyone informed of work that is happening with the regions, more recently with SUAP and a framework for how we think about advancing this work.

Our Ministry is responsible to develop an immediate response to the opioid crisis that includes improvements to mental health and addiction services, and so this falls within our mandate.

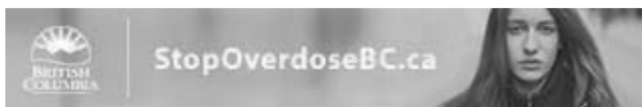
I was called to brief Stephen at 5.30pm yesterday and specifically as it relates to the SUAP proposal for the SAFER initiative. The document attached was not a part of this briefing.

Stephen wanted to understand the SAFER initiative and how it fits with our continuum of care for consideration of provincial support.

Kind Regards,

**Justine Patterson**  
Executive Director, Overdose Emergency Response Centre  
Ministry of Mental Health and Addictions  
201-828 W 8<sup>th</sup> Ave, Vancouver, BC  
604.341.2407 (cell)

*On the Unceded Territory of the Coast Salish*



---

**From:** Tupper, Kenneth HLTH:EX  
**Sent:** September 6, 2019 10:27 AM  
**To:** Patterson, Justine A MMHA:EX <[Justine.Patterson@gov.bc.ca](mailto:Justine.Patterson@gov.bc.ca)>; Emslie, Margaret J HLTH:EX <[Margaret.Emslie@gov.bc.ca](mailto:Margaret.Emslie@gov.bc.ca)>; Clow, Holly HLTH:EX <[Holly.Clow@gov.bc.ca](mailto:Holly.Clow@gov.bc.ca)>; Halsall, Elaine HLTH:EX

<Elaine.Halsall@gov.bc.ca>; Gudmunson, Kathryn HLTH:EX <Kathryn.Gudmunson@gov.bc.ca>

**Cc:** Hayward, Ross HLTH:EX <Ross.Hayward@gov.bc.ca>; MacKenzie, Jennifer E MMHA:EX

<Jennifer.E.MacKenzie@gov.bc.ca>

**Subject:** RE: Pharmaceutical alternatives \_RRT Leads (002)

Hi Justine

Just wondering about the context for this, in light you mentioning on the Island Health call just now about briefing DM Stephen Brown about this at 10:30 this morning?

More information would be helpful for us at MoH MHSU, especially when it's going in front of our DM within an hour of us receiving it.

Thanks

Ken

---

**From:** Patterson, Justine A MMHA:EX

**Sent:** September 6, 2019 9:34 AM

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<Jennifer.E.MacKenzie@gov.bc.ca>

**Subject:** Pharmaceutical alternatives \_RRT Leads (002)

Hi All,

Please find attached an outline of pharmaceutical alternatives for an emergency response including rationale, approaches for a continuum of care and policy framework. This will be helpful information as we start discussing how we can support pharmaceutical alternatives while keeping within the existing regulatory and legislative framework.

We are moving into an evidence informed space and need to identify a clear plan to support these initiatives while adhering to policy framework and PHO recommendations, and working within the context of a public health emergency.

Given that we know the overdose death rates remain unacceptably high and the highest in Canada, and that overdose event rates and severity of events are increasing, taking the typical approach of pilot, evaluation and expansion is not ideal. We also know that anoxic brain injury and other poor health outcomes are emerging as a result of repeated and complex overdose events, which will create significant downstream health system impacts. We need to scale and evaluate simultaneously to save lives, and ensure appropriate provincial and HA oversight and an independent evaluation that can support pivoting our response if required and addressing any unintended health consequences.

I suggest a phased approach to TiOAT expansion:

s.13; s.16

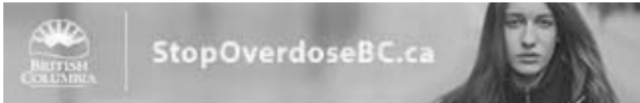
I look forward to discussing this further.

Kind Regards,

**Justine Patterson**

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*On the Unceded Territory of the Coast Salish*



## **Yamashita, Ann MMHA:EX**

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**From:** Patterson, Justine A MMHA:EX  
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**Subject:** FW: Tool kit  
**Attachments:** Safe Supply Tool Kit 2019\_EN.pdf

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**From:** Patterson, Justine A MMHA:EX  
**Sent:** September 6, 2019 2:02 PM  
**To:** Tupper, Kenneth HLTH:EX  
**Subject:** Tool kit

# **Toolkit for Substance Use and Addictions Program Applicants**

Stream 2 – Increasing Access to Pharmaceutical-Grade Medications

**AUGUST 2019**





## **Toolkit for Substance Use and Addictions Program Applicants**

### *Stream 2 – Increasing Access to Pharmaceutical-Grade Medications*

The use of pharmaceutical medication to treat opioid use disorder is supported by extensive evidence in Canada and around the world. While oral medication (e.g., methadone and buprenorphine-naloxone) is the predominant form of opioid agonist treatment (OAT), international and domestic studies also support the supervised use of injectable medication (iOAT) (e.g., diacetylmorphine; hydromorphone) for certain individuals struggling with severe, chronic, opioid use disorder.

More recently, Canadian programs are providing services that build on the established OAT and iOAT models. These innovative projects provide prescription opioids to treat substance use disorder, with appropriate prescriber oversight, through models that provide more flexibility for patients (e.g., less restrictive eligibility requirements; more medication options).

Recognizing the scale of the ongoing opioid overdose crisis, and the need to support the development of new evidence-based approaches, Health Canada has launched an anticipatory call for pilot projects. As noted in the Guide for Applicants, applications submitted under this stream must demonstrate: linkages to provincial and/or territorial health systems; health care provider oversight; plan for ethics review; involvement of people with lived and living experience of past or current substance use; and commitment to participate in and contribute to an independent, third-party evaluation, coordinated by Health Canada, which will include common outcome and performance indicator measures across projects. This robust evaluation will help determine if the new models deliver the expected results for people struggling with opioid use disorder.

To assist you in applying for pilot project funding, Health Canada asked a group of experts to bring together research, best practices, as well as regulatory and public health considerations, and develop a set of reference resources that represent current expert opinion in this developing field. This Task Team consisted of public health practitioners, researchers, people with lived and living experiences, pharmacists, and people who work in harm reduction and community health organizations from across the country:

- Julia Bareham, Information Support Pharmacist, RxFiles Academic Detail;
- Mark Barnes, Director of Pharmacy Services, Owner RespectRx, Pharmasave;
- Dr. Brian Emerson, Deputy Provincial Health Officer (acting), British Columbia Ministry of Health;
- Catherine Hacksel, Program Manager at Ottawa Inner City Health;
- Carol Hopkins, O.C., MSW, LL.D (hons), Executive Director, Thunderbird Partnership Foundation;
- Dr. Elaine Hyshka, Assistant Professor, School of Public Health, University of Alberta;
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- Dr. Karen Mazurek, MD CCFP, Deputy Registrar, College of Physicians and Surgeons of Alberta;
- Dr. Carole Morissette, MD FRCPC, Médecin conseil, Direction régionale de santé publique du CIUSSS du Centre-Sud-de-l'Île-de-Montréal;
- Wendy Muckle, Chief Executive Officer, Ottawa Inner City Health, Inc.; and
- Jordan Westfall, co-founder Canadian Association for Safe Supply, major contributor to *Safe Supply: A Concept Paper*.
- *Toolkit written on behalf of the Task Team by Rebecca Penn*

They assembled the attached resources that you may wish to consider, as you complete submissions for this funding stream. We have also included a copy of the recently published British Columbia Centre on Substance Use “Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder”, as well as a selection of references where you can obtain further information.

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# **Section 1**

## **Safer Supply: A Continuum of Care for People Who Use Drugs**

# 1. Safer Supply: A Continuum of Care for People Who Use Drugs

There is a continuum of care for addressing social and health concerns related to the use of substances that ranges from harm reduction approaches to addiction treatment approaches, and safer supply programs exist along this continuum. Similarly, safer supply models exist along a continuum, anchored at one end by programs designed with as few barriers as possible (e.g., flexible eligibility requirements, unobserved dosing), and highly-clinical models of opioid agonist treatment (OAT) on the other end (e.g., multiple witnessed daily doses, illegal drug abstinence). The options for safer supply that are explored in this document are those that could be implemented rapidly, in accordance with current legislation and regulations.

Operationalizing safer supply programs at this time will build on medical models that require prescriptions and some degree of monitoring and care from authorized health professionals and that operate within the parameters set by the current legislation and regulations. The medical models discussed represent a diverse range of programmatic and pharmaceutical alternatives for people who use drugs who are dependent on the contaminated and unpredictable illegal drug market. In particular, “flexible” models are highlighted as offering emerging practices for safer supply.

## A continuum of care for safer supply models

Models provide a way of categorizing approaches and describing characteristics and goals of programs. In reality, programs may draw on aspects of different models to address the needs, cultures, and drug supply contexts of their community. The models suggested here are ‘ideals’. We provide examples of programs that best fit as representative of a model, but acknowledge that they may also include characteristics of other models. The models are not mutually exclusive; together they offer a continuum of approaches for providing regulated alternatives to illegal drugs. Ideally, people who use drugs will have access to services from different models, and be able to move between models according to their needs and goals, as requested. The models provide a continuum that recognized that everybody, from people with a substance use disorder to the person who uses occasionally, is at risk of an overdose when consuming substances that may be contaminated with fentanyl or similar toxic substances.

A variety of models in many different settings are critical to meet the diverse needs of the broad population. Appropriateness of models is dependent upon factors such as community context, need, jurisdiction-specific regulations, existing services, available resources, and drug scene. Models need to be tailored to these factors and reflect the commitment to a public health and harm reduction approach and the provision of low-threshold accessible services.

**Table 1.1** provides an overview of three broad approaches for offering safer supply programs:

*Traditional* approaches, such as the provision of opioid agonist therapies, are embedded in the treatment system and are largely oriented towards treating opioid use disorder rather than safer supply. However, when needed, the focus of OAT can be shifted to the provision of safer supply, rather than treatment, by lowering eligibility requirements, focusing on patient-centered goals, focusing on reducing use of illegal drugs (and related harms), and by employing a low-threshold/harm reduction approach to providing access to regulated opioid alternatives to the illegal drug supply. Traditional approaches provide an increasingly wider range of service designs, as well as pharmaceutical options that can be used alongside safer supply prescribing. For example, safer supply prescribers of pharmaceutical opioids (across all models) may prescribe slow-release oral morphine (Kadian®) as a ‘backbone’<sup>1</sup>, alongside Dilaudid® tablets or injectable hydromorphone<sup>2</sup>.

*Enhanced models* expand on OAT to offer lower-barrier access to treatment of opioid use disorder *and* to safer supply, i.e., pharmaceutical alternatives to illegal opioids. Injection opioid agonist treatment (iOAT) programs are finding ways to reduce the barriers to access and retention for people who use opioids by expanding eligibility criteria to opioid use (rather than opioid use disorder) and offering a harm reduction approach to drug use. Enhanced models provide observed consumption, similar to traditional OAT models. There is a strong evidence base for iOAT that is continuing to be developed. There are examples of enhanced models currently being piloted in settings such as overdose prevention sites and supportive housing.

Finally, *flexible models* refer to the growing number of community-based initiatives that seek to provide pharmaceutical alternatives to the illegal drug supply, with as few barriers as possible and without expectation of transition to treatment. Flexible models seek to provide a nimble, responsive, and less treatment-intensive and less medicalized approach to providing safer supply programs. In general, these models offer daily-dispensed drugs, prescribed by a doctor or nurse practitioner, which may be consumed unobserved or observed, as needed and appropriate. However, flexible models may take a variety of forms, including buyer’s club models as long as there is appropriate prescriber oversight and that activities remain within the parameters set by the current legislation and regulations. Although these flexible models are evidenced-informed in their design, there is currently limited guidance for prescribers and therefore prescribers may need to extrapolate from evidence and iOAT and other prescribing guidelines, and consult with their clinical peers to provide care. *Flexible* models have strong potential for scaling up and are highlighted here as a promising model for pilot projects and evaluation.

All approaches, from *Traditional* to *Flexible* models, can provide a regulated alternative to the illegal drug supply for people who use drugs, and are necessary to address the ongoing opioid crisis. While the Task Team acknowledges the importance of *Traditional* approaches that are founded on well-established OAT models (e.g., buprenorphine/naloxone, slow-release morphine, and methadone), these approaches will not be discussed in detail here. A detailed analysis of *Enhanced* and *Flexible* models are presented in **Section 3.1**.

---

<sup>1</sup> Slow release oral morphine (SROM, brand name Kadian®) is considered an appropriate 'back bone' because of its long acting pharmacological properties.

<sup>2</sup> Hydromorphone (brand name Dilaudid®) are short acting.

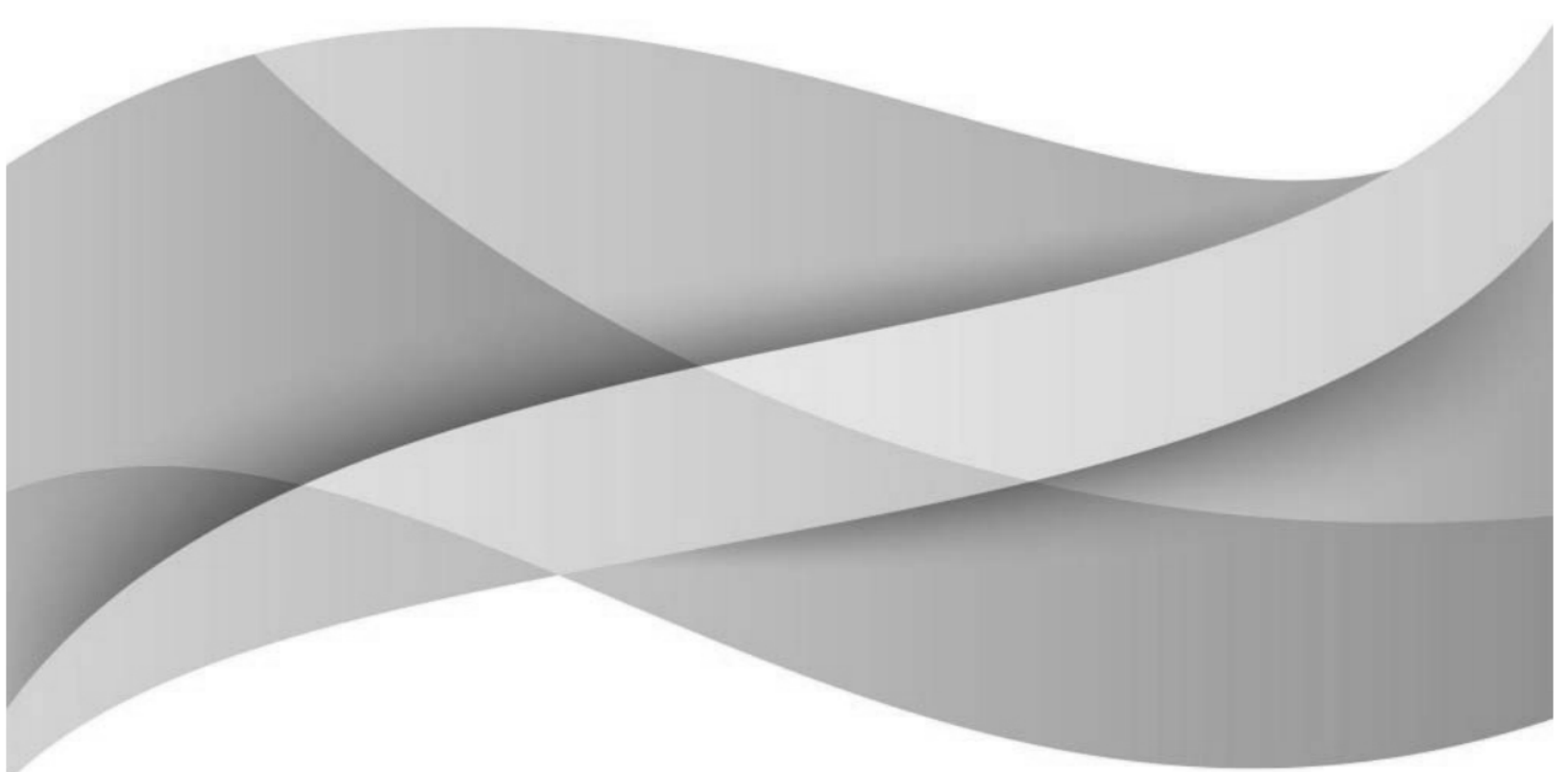
**Table 1-1 - Approaches to safer supply programs**

	Models that can be implemented within existing legislative framework			Other models (out of scope)
	Traditional	Enhanced	Flexible	Without prescriber oversight
<b>Target Population</b>	People with substance use disorder who are seeking treatment.	People with substance use disorder, for whom traditional treatment has been unsuccessful.	People who use illegal substances, whose needs are not met by highly-structured models.	People who use opioids or stimulants.
<b>Models</b>	OAT; iOAT Multiple models.	Adapted iOAT/Tablet iOAT (TiOAT) for safer supply. Multiple options: 1. Comprehensive/dedicated (Crosstown) 2. Integrated/embedded (PHS, MOP); 3. Pharmacy model; Observed consumption. Lower threshold entry to iOAT model of safer supply. These may also include the prescription of regulated stimulants.	Daily dispensed; low threshold; self-titrated; observed and unobserved consumption; hub and spoke (rural areas). Already being done informally in private and primary care practices.  Any proof of concept project that meets the requirements of appropriate prescriber involvement (e.g., a medical model) and permissible within the current regulatory and legislative frameworks.	Non-medicalized buyers clubs / compassion clubs.
<b>Evidence</b>	Adheres to current clinical guidelines.	iOAT as treatment has a strong evidence base; TiOAT as lower barrier treatment is being piloted. iOAT and TiOAT as safer supply models require further evaluation.	Requires pilot testing and evaluation to develop an evidence base.	
<b>Characteristics</b>	Medicalized; embedded in addiction treatment and primary care systems; uses contingency management.	Medicalized; embedded in addiction treatment and primary care systems; can require multiple visits a day for observed dosing; contingency management; wrap-around care.	Low threshold, harm reduction and public health informed approach. Embedded in primary care, SCS/OPS/CTS, or housing with pathways to health, social, and addiction treatment services.	Non-medicalized; public health approach.
<b>Goals</b>	Patient led goals: e.g. reduce/stabilize drug use, work towards abstinence.	Patient led goals around reducing illegal drug use or stabilizing use, if desired.	Reduce illegal drug use and related risks.	Provide safer supply of regulated drugs.
	Reduce risks of overdose and harms; Increase engagement with health, social services; provide primary care; reduce petty crime, sex work; reduce reliance on illegal market. Engage with highly marginalized/at risk people who typically do not access health and social services.			



# Section 2

## A Review of the Evidence



## 2. A Review of the Evidence

Given that safer supply programs are only just beginning, the evidence for safer supply interventions has yet to be established. However, the foundation of safer supply programs is built on the strong evidence available for the effectiveness of reducing harm through the provision of regulated pharmaceutical-grade opioids to people who use illegal opioids under the supervision of health providers (referred to as managed opioid programs, maintenance therapies, opioid-agonist treatment [OAT], or injection opioid agonist treatment [iOAT]). This evidence is reviewed here.

### *Opioid Agonist Treatment*

A brief review of the evidence supporting oral OAT is provided here because it is an evidence-based approach for treating opioid use disorder<sup>1</sup> (OUD) and a critical tool for addressing the opioid overdose crisis<sup>2</sup>. In addition to the treatment goals of OAT (i.e., reducing and/or stabilizing drug use), OAT may be used for safer supply goals, i.e., reducing illegal drug use. OAT may be offered through oral formulations (e.g., methadone, buprenorphine-naloxone) or injectable formulations (e.g., diacetylmorphine, hydromorphone). Studies are also examining the potential harm reduction and protective effects of OAT, for example, improving social integration, increasing HIV treatment adherence, and possibly reducing hepatitis C infection<sup>3,4</sup>, and reducing initiation into injection drug use<sup>5</sup>.

Studies<sup>6</sup> suggest that diversified opioid-agonist treatments are needed for people with opioid use disorder. Opioid agonist treatments have evolved to include pharmaceutical options beyond methadone, such as buprenorphine-naloxone (brand name Suboxone®), and slow-release oral morphine (SROM - brand name Kadian®). A study in Switzerland found that with the addition of new OAT alternatives, demand for methadone had decreased, yet methadone remained the most commonly used OAT<sup>4</sup> and is considered a second-line treatment for OUD<sup>1</sup>. Current Canadian guidelines<sup>1</sup> recommend buprenorphine-naloxone as a first line treatment because of its superior safety profile (6 times safer than methadone in terms of overdose risk) and its potential for flexible take-home dosing and fewer required medical appointments.

While methadone and buprenorphine have been most prominently used for people with more stable opioid use disorder, slow-release oral morphine may show promise for those with less stable OUD<sup>7</sup>. There is a growing evidence base for SROM that suggests that SROM has efficacy rates similar to methadone, but with a better safety profile, including fewer drug-drug interactions, and greater improvements in patient-reported outcomes, such as tolerability, alleviation of cravings and withdrawal symptoms, and treatment satisfaction. Canadian guidelines recommend that SROM be prescribed by specialists and as daily witnessed doses because of the potential patient and public safety risks<sup>1</sup>.

In addition to an expansion in the pharmaceutical options for OAT, injectable opioid agonist treatment (iOAT) provides an approach for those who prefer to inject. Diacetylmorphine (heroin) and hydromorphone (brand name Dilaudid®) are prescribed in iOAT programs.

### *Heroin-assisted treatment*

For over a century, unsupervised prescription injectable diacetylmorphine has been available in the United Kingdom<sup>8 9 10</sup>, and Switzerland has provided supervised prescription diacetylmorphine as a standard drug treatment for opioid use disorder since 1999<sup>11</sup>. Supervised prescription diacetylmorphine is now provided in Germany, Denmark, the Netherlands<sup>10</sup>, and increasingly in Canada, primarily for those who have had a poor response to methadone treatment. The prescription of diacetylmorphine, also known as heroin-assisted treatment (HAT) has been demonstrated to be effective and cost-effective in Europe and Canada<sup>12 13 14</sup>. A study conducted in Canada (NAOMI) involved participants in Montreal and Vancouver who had failed methadone-based treatment. They were randomized to receive either heroin assisted treatment or methadone maintenance treatment. Corresponding to the results found in studies in England, Spain, Germany, Switzerland, and the Netherlands<sup>10 12 13 14 15</sup>, this Canadian study<sup>16</sup> found that overall, HAT is more effective than methadone. More specifically, it found:

- Those receiving HAT reduced their use of illegal drugs more significantly than those receiving methadone;
- The HAT group showed significantly greater improvements in their medical and psychiatric status, economic status, employment situation, and family and social relations compared to the group receiving methadone;
- Other positive benefits of HAT, such as reduced mortality, reductions in needle sharing, increased treatment retention, reduced risk of acquiring HIV, hepatitis B and C, improved housing and employment stability, and dramatic reductions in criminal activity.

### *Hydromorphone: an effective and acceptable alternative to diacetylmorphine*

A Vancouver-based study<sup>17</sup> examined whether injectable hydromorphone was an effective and acceptable alternative to diacetylmorphine prescription for iOAT programs. Injectable hydromorphone was found to be non-inferior to diacetylmorphine; additionally, retention in treatment was high (over 80%) and there were fewer side effects among people receiving hydromorphone. The study authors conclude that hydromorphone is a suitable alternative to diacetylmorphine prescription, particularly in jurisdictions where diacetylmorphine is not easily available. Guidelines are now available in BC<sup>18 19</sup> and nationally<sup>20</sup> for both forms of opioid agonist treatment programs that use injectable opioids.

### *Harms and recommended practices for injecting oral opioids*

Recently, prescribers have begun prescribing hydromorphone tablets as a regulated alternative opioid. There are groups of people who use drugs who have expressed a strong preference for

tablets over injectable formulations. For example, in Quebec, crushing and injecting tablets is a common practice and first choice for at least a 40 per cent of people who inject drugs<sup>21</sup>. Further, access to injectable high-potency hydromorphone is hampered by provincial formulary caps and/or exclusions, thereby making tablets a more affordable and accessible option. However, health care providers may have concerns for their patients about potential health risks associated with injecting crushed and dissolved tablets, as well as liability concerns about prescribing and dispensing a tablet that has not been approved for injection.

Literature addressing the injection of opioids manufactured for oral consumption highlights the specific health issues that can occur, which include<sup>22 23</sup>:

1. skin and soft tissue injuries (e.g., skin ulcers and cellulitis)
2. lung, heart and other conditions related to blood vessels (e.g., blood clots, endocarditis)
3. local and generalized infections (e.g., abscesses around injection sites and generalized blood infections)

These health issues can be caused by viral, bacterial, or other matter introduced by injecting in non-sterile conditions. They can also be caused by the drug itself, but more commonly, by ingredients in the drug (such as bulking agents, coatings, waxes or gels) that are included to make the oral formulation work as intended, for example to maintain its stability, or to control the release of the drug once it is swallowed, as well as prevent tampering. These ingredients may have adverse effects on the body when they are dissolved into solution and injected. They can clog needles or filters, become lodged within the skin or other blood vessels, and cause medical complications<sup>24 25</sup>.

The available research on the beneficial effects of filtering opioids manufactured for oral use prior to injection provides a number of harm reduction practices that address the harms introduced by both non-sterile conditions as well as from excipients, these include<sup>21 22</sup>:

- handwashing prior to injection and alcohol swabbing at the injection site;
- using sterile water to prepare the solution to be injected;
- use of sterile injection equipment;
- filtering the solution using a combined Sterifilt® brand filter and cotton filter.

With proper filtration, much of the excipients are excluded, leaving primarily the active component of the drug<sup>22 24</sup>. A study<sup>21</sup> in Quebec found that the combination of a Sterifilt® brand filter and cotton filter makes it possible to optimize the filtering capacity of Sterifilt® while maintaining a good amount of active ingredients in filtered solutions. Based on this research, oral drugs injected using harm reduction practices may be a better alternative to illegal drugs procured from the illegal market<sup>22 23 24</sup>. Another recommendation based on this research could be that if oral hydromorphone tablets were to be provided to people who may

inject them (or use them intra-nasally or smoke them), it would be best to prescribe hydromorphone tablets with the least amount of excipients in them, or the least amount of excipients that are harmful if injected<sup>22</sup>. For example, immediate release tablets are likely to have less (or less harmful) excipients compared to sustained released tablets. This recommendation also coincides with the reported preference of people who use drugs for Dilaudid® over generic formulations of hydromorphone.

### *Stimulant Substitution Programs*

Thus far emphasis has been placed on a safer supply for opioids because of the unpredictable and toxic opioid supply on the illegal market. There are some reports that illegal stimulants may also be vulnerable to contamination, and polysubstance use is common. This supports the need for safer supply of stimulants. Research evidence for stimulant substitution treatment is currently not as strong as that for opioid substitution treatment, and further research is needed<sup>26 27</sup>.

Existing treatment options for stimulants almost exclusively focus on abstinence-based approaches, and operate on appointment-based schedules that can be difficult for people to comply with. Further, many may not offer counseling and social supports appropriate to the situations of people who use stimulants<sup>27 28</sup>. The integration of a harm reduction approach in managed stimulant programs makes it an appealing alternative to many of the existing treatment options for stimulant use.

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# Section 3

## Establishing Safer Supply Programs



### 3. Establishing Safer Supply Programs

The following tools are intended to support decision-making for program design considerations. They include:

- 3.1** Service model design
  - 3.1.1** Comparison of flexible and enhanced models of safer supply
  - 3.1.2** Considerations for observed and unobserved dosing models
  - 3.1.3** Considerations for rural and remote areas
  - 3.1.4** Case studies of current programs
- 3.2** Selecting and obtaining regulated pharmaceutical drugs for these models
  - 3.2.1** Regulated pharmaceutical-grade opioids used in safer supply programs
  - 3.2.2** Regulated pharmaceutical-grade stimulants used in safer supply programs
  - 3.2.3** Map: Process for acquiring controlled substances via existing regulations
- 3.3** Considerations for creating operational and clinical protocols
- 3.4** Site requirements and staffing considerations

### **3.1 Service Delivery Design**

A critical element of service delivery design is to engage with people who will use the program: i.e., people who use drugs. By consulting with and including people who use drugs in the design, services are more likely to meet the needs of the target population.

There are different service delivery models that can be adapted to meet the needs and cultures of the local context in which the program will operate. There are also legislative and regulatory considerations for service delivery design.

This section guides a safer supply program design team through considerations for service delivery models by:

- 3.1.1** Presenting a comparison of Enhanced and Flexible models
- 3.1.2** Presenting the regulatory considerations for observed and unobserved dosing
- 3.1.3** Service delivery design considerations for rural and remote areas
- 3.1.4** Providing case studies of programs currently being piloted

### 3.1.1 Flexible and enhanced safer supply program models

In Section 1, a continuum of care for safer supply programs for people who use drugs was introduced. This continuum of care ranges from *Traditional* approaches (e.g., OAT), to *Enhanced* models, and to *Flexible* models (see **Table 1-1** in Section 1). A detailed analysis of *Enhanced* and *Flexible* models is presented below, including key characteristics, settings, strengths, limitations, anticipated benefits, potential harms, and strategies for mitigating harms.

#### Enhanced Models

Enhanced models provide observed consumption and contingency management, similar to traditional OAT models, however, they are adapted to provide a lower barrier approach to delivering regulated alternatives to illegal drugs, i.e., safer supply. Injection opioid agonist treatment (iOAT, and TiOAT – tablet injection opioid agonist treatment) may be used as either treatment for opioid use disorder or for providing a safer supply of regulated alternatives to opioids purchased from the illegal market. The focus of enhanced models is on the latter goal: *iOAT and TiOAT as an approach for providing a regulated supply of opioids and/or stimulants*. Existing iOAT and TiOAT programs are finding ways to reduce the barriers to access and retention for people who use opioids, such as offering programs in supervised consumption sites, overdose prevention sites, and supportive housing; by changing eligibility criteria to opioid use (rather than opioid use disorder); and offering a harm reduction approach to drug use.

The British Columbia Centre for Substance Use (BCCSU) identified three models of care in their iOAT guidance document (BCCSU 2017), which may be adapted to have a safer supply focus on reduced *illegal* drug use and related harms, rather than a treatment focus on reduced drug use:

#### **A. Comprehensive and dedicated supervised injectable opioid agonist treatment program (iOAT) – adapted to deliver safer supply**

*Example: Crosstown Clinic in Vancouver BC*

- Provides a comprehensive model of care alongside supervised iOAT;
- Often located in hospitals or clinics, or as a standalone facility;
- Services are co-located at the clinic (e.g., pharmacy, primary care health providers, social workers) or are referred to community services; and
- Services include addictions care, primary care, mental health care, chronic pain management, and psychosocial services such as housing, employment, trauma therapy and specialized services for women, youth, and Indigenous peoples.

**Strengths:** Offers continuity of care, “one-stop shop”; preferred option for people who lack clinical and social stability; few/no barriers to wrap-around services; solid body of evidence supporting iOAT. Has potential to pilot lower threshold approaches such as unobserved dosing and unobserved titration, permitting polysubstance use, and offering stimulant substitution treatment.

**Limitations:** Resource-intensive; requires on-site pharmacy that is compliant with compounding regulations; not appropriate for community with lower demand or capacity for iOAT; there may be challenges in de-intensifying treatment.

**Anticipated benefits:** Reduces clients’ use of illegal drugs and reliance on illegal market, increases engagement with primary health care and social services, decreases mortality related to overdose and other related harms; reduced involvement in crime and sex work.

**Potential harms:** Maintains clients’ use of injection if other modes of consumption are not permitted (e.g., many sites do not have inhalation facilities); maintains dependence on illegal market if optimal dose or optimal drug is not provided.

**Mitigation strategies to reduce potential harms:** Provide a range of drugs and formulations (e.g., stimulants, opioids; pills, injectables); work closely with clients to determine their optimal dose and offer alternatives such as slow release oral morphine, e.g., Kadian®, as a ‘backbone’ in addition to their regulated opioids; have smoking facilities; permit polysubstance use and multiple modes of consumption (i.e., intranasal, oral ingestion, injection, inhalation).

## **B. Integrated or embedded supervised injectable opioid agonist treatment program - adapted to deliver safer supply**

*Examples:*

- *Ottawa Inner City Health’s Managed Opioid Program is located within supportive housing and supervised injection site.*
- *Portland Hotel Community Services Society has an existing iOAT program and is piloting a tablet injectable (TiOAT) program at their Molson overdose prevention site in Vancouver BC.*
- iOAT program, adapted for safer supply, is integrated with existing services at community health centres (CHC), harm reduction programs (including supervised consumption sites, overdose prevention sites), or supportive housing;

- Extends the range of services to existing clients, and also might attract new clients who would also benefit from the broader range of health and social services and addictions treatment offered on site, or through referral pathways to providers in the community; and
- Offers both pharmaceutical opioids and/or stimulants as regulated alternatives to the illegal contaminated market.

**Strengths:** Lower resource requirements compared to comprehensive/dedicated iOAT or traditional OAT models; provides continuity of care; low barriers to additional services; appropriate for locations with lower demand for iOAT, e.g., rural areas; growing body of evidence supporting embedded iOAT. Has the potential to pilot lower threshold approaches such as unobserved dosing and unobserved titration, permitting polysubstance use, offering the full continuum of care of OAT and referral to recovery services, and offering stimulant substitution treatment.

**Limitations:** Requires on-site pharmacy or pharmacy delivery (compliant with College regulations for compounding); requires additional staffing and dedicated space.

**Anticipated benefits:** Reduces clients' use of illegal drugs and reliance on illegal market, increases engagement with primary health care and social services, decreases mortality related to overdose and other related harms; reduces involvement in crime and sex work.

**Potential harms:** May maintain clients' use of injection if smoking or intranasal consumption are not permitted; maintains dependence on illegal market if optimal dose or optimal drug is not provided.

**Mitigation strategies to reduce potential harms:** Provide a range of drugs and formulations (e.g., stimulants, opioids; pills, injectables); work closely with clients to determine their optimal dose and offer oral opioid agonist treatment options such as slow-release oral morphine (Kadian®) as a 'backbone' in addition to other prescribed pharmaceutical opioids; have smoking facilities; permit polysubstance use alongside observed dosing; and permit multiple modes of consumption.

### C. Pharmacy-based supervised injectable opioid agonist treatment program – adapted to deliver safer supply

*Example: PHS Community Services Society in Vancouver was piloting this model.*

- This model may be more appropriate for settings in which the first two models are not feasible (e.g., in rural settings);
- Primary care and addiction services are offered in existing clinics, and observed dosing is undertaken by trained pharmacists in select community pharmacies; and

- Referrals are made to community agencies for services such as mental health care, chronic pain management, and psychosocial services (e.g., counseling, employment, housing) and specialized services for women, youth, and Indigenous peoples.

**Strengths:** Appropriate for communities with low demand for iOAT; appropriate for clients on a stable dose; lower resource requirements.

**Limitations:** Requires community pharmacy with appropriately trained staff to dispense, supervise, and respond to adverse events, with dedicated space for supervised consumption, and facilities compliant with College regulations for compounding. There may be higher barriers to additional services. Although barriers to treatment are reduced, it is still high treatment intensity in that clients have to attend pharmacy multiple times per day for dosing.

**Anticipated benefits:** Reduces clients' use of illegal drugs and reliance on illegal market, decreases mortality related to overdose and other related harms; reduces involvement in petty crime and sex work; lower treatment intensity enables more time to participate in other activities (child care, work); increases access in communities that have few social services locally.

**Potential harms:** Maintains clients' use of injection in the absence of inhalation facilities; maintains dependence on illegal market if optimal dose or optimal drug is not provided; complicates connections to social and health services because they are not onsite.

**Mitigation strategies to reduce potential harms:** Provide a range of drugs and formulations (e.g., stimulants, opioids; pills, injectables); work closely with clients to determine their optimal dose and offer other OAT alternatives such as slow release oral morphine, e.g., Kadian®, as a 'backbone' in addition to their regulated supply of opioids; have smoking facilities; permit polysubstance use alongside observed dosing; have outreach workers attend community pharmacies to provide support and referrals; prescribers, support workers, and pharmacists work together to provide care.

## **Flexible Models**

*Examples:*

- *The Liverpool model (1980s UK)*
- *London Intercommunity Health Centre's model (Ontario)*
- *Dispensing machine model (yet to be piloted)*
- *BCCDC low barrier oral hydromorphone feasibility pilot (upcoming)*

Flexible models refer to the growing number of community-based initiatives that seek to provide regulated alternatives to the toxic illegal drug supply with as few barriers as possible, in a flexible and responsive manner. In general, these models offer daily-dispensed drugs,

prescribed by a doctor or nurse practitioner, which are consumed unobserved, as needed, or frequently dispensed drugs for observed dosing. Flexible models may involve a mix of observed and unobserved titration and dosing, according to the needs of their clients. Flexible models have strong potential for scaling up and are highlighted here as an emerging model for pilot projects and evaluation.

- Primary care providers at community health centres or community clinics prescribe hydromorphone to select clients at high risk of overdose or harm.
- Clients are seen daily at first, then weekly, then monthly or as appropriate by the prescriber to monitor health and wellness, and clients pick up daily-dispensed prescription at a community pharmacy, clinic, or potentially, a dispensing machine. Consumption is not observed, except for those for whom there are health and safety concerns (e.g., those who are consuming alcohol and/or benzodiazepines).
- Additional services (wrap-around care) may be provided on-site with few/no barriers, or referred to community providers through directed pathways.

**Strengths:** Lower resource requirements; leverages existing relationships between prescribers/primary health care teams and clients. Less treatment intensive (i.e., observed dosing is not required, unless indicated for specific clients) and so less demanding on clients (e.g., do not have to attend clinic/pharmacy multiple times per day). Provides flexible and responsive care to people who use drugs (not necessarily those with opioid use disorder), including those who use stimulants; have the potential to be scaled up and to reach a wider group of people who use drugs.

**Limitations:** Evidence-informed – requires proof-of-concept piloting. Current practice suggests improved health benefits and greater stability, but it is unclear that these positive outcomes are due to safer supply because consumption is not observed. Current practice demands prescribers carefully document their rationale, including how their decision-making is evidence informed and in line with practices of their peers. This approach may add additional burden to already over-stretched organizations and primary health care teams.

**Anticipated benefits:** reduces clients' use of illegal drugs and reliance on illegal market; decreases mortality related to overdose and other related harms; reduces involvement in petty crime and sex work; lower intensity approach enables more time to participate in other activities (child care, work); increases connection to health and social services.

**Potential harms:** The biggest concerns are the potential for diversion, and prescriber liability should a client overdose or experience harm. Diversion is a concern in areas where the drug supply is contaminated with carfentanil, which increases people's tolerance; the volume for the prescribed dose that would be needed to match a very high tolerance may not be appropriate or desirable. This might encourage people to exchange or sell their prescribed medications for fentanyl, carfentanil or other illegal drugs. By adding additional service demands to already under-resourced organizations, this may limit access to services

across the organization; i.e., existing resources are deployed for new flexible safer supply programs at the expense of other programs.

***Mitigation strategies to reduce potential harms:*** provide a range of drugs and formulations (e.g., stimulants, opioids; pills, injectables); work closely with clients to determine their optimal dose and offer opioid alternatives such as slow-release oral morphine, Kadian®, as a ‘backbone’ in addition to their prescribed opioids; permit polysubstance use; prescribers, support/outreach/peer workers, and pharmacists work together to provide care. Organizations require sustainable and adequate funding to effectively provide a full range of services.



**Table 3-1 – Summary of considerations related to *Flexible* and *Enhanced* models for safer supply**

	Flexible	Enhanced		
	Embedded and integrated Daily dispensed HDM	Pharmacy - iOAT/TiOAT	Embedded or Integrated iOAT/TiOAT	Comprehensive and dedicated iOAT
<b>Examples</b>	London InterCommunity Health Centre (ON); Liverpool Model (UK 1980s).	Portland Hotel Society (PHS), Vancouver, was piloting this model.	PHS, Vancouver (TiOAT); Managed Opioid Program (MOP), Ottawa (iOAT).	Providence HC Crosstown clinic, Vancouver; Sheldon M. Chumir Health Centre, Calgary.
<b>Setting</b>	CHCs / Housing	Community pharmacy	SCS/OPS/CTS; Supportive housing	Hospital/clinic
<b>Observed dosing requirements</b>	Unobserved or observed. Tiered.	Observed. Tiered.	Observed. Tiered.	Observed. Tiered.
<b>Prescribing model</b>	Individual prescriber-patient. Daily dispensed.	Individual prescriber-patient. Frequently dispensed, with set minimum time between doses.	Individual prescriber-patient. Frequently dispensed, with set minimum time between doses.	Individual prescriber-patient. Frequently dispensed, with set minimum time between doses.
<b>Type of drug and mode of consumption</b>	Hydromorphone injectable/tablets; Dexedrine, Adderall, Vyvanse. Injection, oral, intranasal consumption.	Hydromorphone injectable/tablets. Injection, oral, intranasal consumption.	Hydromorphone injectable/tablets (exploring fentanyl). Injection oral, intranasal consumption.	Diacetylmorphine (only Crosstown), hydromorphone injectable. Injection, oral, intranasal consumption.
<b>Pharmacy support</b>	Community pharmacy, with compounding for multi-dose vials.	Community pharmacy with compounding for use of multi-dose vials.	Community compounding pharmacy; RN compounds multi-dose vials as needed, as permitted by regulatory colleges.	On site compounding pharmacy.
<b>Wrap-around care</b>	Available with low barriers. Embedded in primary care, with other health and social services available, but not required. Low barriers to additional services.	Available. Connected to primary care and referrals to other health and social services when needed.	Available with low barriers. Connected to primary health care, direct pathways to health and social services, but not required.	Available with low barriers. Direct pathways to primary health and social services; “one stop shop”.
<b>Evidence-base</b>	Safer supply approaches are extrapolated from the evidence for iOAT. No current guidelines. Requires proof of concept pilot projects.	Safer supply approaches are extrapolated from the evidence for iOAT. No current guidelines. Requires further piloting.	Safer supply approaches are extrapolated from the evidence for iOAT. No current guidelines. Requires further piloting.	Strong evidence. iOAT Guidelines have been established. Requires continued evaluation as an approach for safer supply.
<b>Resources required</b>	Observed dosing requires room, staff. Unobserved dosing requires fewer resources.	Need infrastructure for observed dosing (e.g., room, staff) and need pharmacy buy-in.	Expand existing infrastructure for observed dosing (room, staff).	Resource intensive; requires a sustainable supply of diacetylmorphine (or hydromorphone).
<b>Implementation considerations</b>	Cost: Need hydromorphone listed in formularies at appropriate concentrations; availability of single use vials or compounding pharmacy for multi-dose vials.  Regulatory issues with Colleges (e.g., off-label injection use of oral medications; compounding, prescribing and assessment frequency).			1. Considerations for securing diacetylmorphine supply. 2. Cost of infrastructure. 3. Needs of the community.
<b>Comments</b>	Lower cost requirements, especially for unobserved dosing models, or off-site observed models (i.e., pharmacy-model).	Potential option for settings such as rural/remote and Indigenous communities. Scalability based on pharmacy support and capacity. Appropriate for patients on a stable dose. Less intensive treatment requirements. Lower cost requirements than enhanced models.	Lowering barriers to iOAT. Lower cost requirements than comprehensive models. <b>Vision:</b> SCS/OPS/CTS models supply hydromorphone (with limits on dose and frequency) to clients, after medical assessment.	Lowering barriers to OAT.

### 3.1.2 Regulatory considerations for observed and unobserved dosing

**Table 3-2 – Regulatory considerations for observed and unobserved dosing**

Question	Observed	Unobserved	Legislation/ Regulation and Oversight
What do the guidelines say?	Currently, there are no guidelines for prescribing stimulants or opioids as a pharmaceutical alternative to the illegal drug supply. The lack of guidelines creates a grey area. Prescribing off-label and outside of existing guidelines has left some prescribers concerned that they will be held to criminal, professional, and medicolegal liability should harm come to their patient, or to the community. Key stakeholders who are prescribing safer supply reported feeling ethically-bound to respond to the harms that they see arising for patients who have a substance use disorder and/or are experiencing harms (e.g., overdose) related to the toxic illegal drug supply.		<ul style="list-style-type: none"><li>• Professional regulatory colleges.</li><li>• Current guidelines that may inform safer supply practice:<ul style="list-style-type: none"><li>• iOAT guidelines,</li><li>• OUD guidelines,</li><li>• Stimulant prescribing guidelines for ADHD.</li></ul></li><li>• Needed: guidelines for prescribing controlled substances as safer supply.</li></ul>
	OAT and iOAT guidelines provide guidance for observed safer supply prescribing, including contingency management.	In the absence of guidelines for prescribing controlled substances for safer supply, prescribers document how they: <ul style="list-style-type: none"><li>• follow standards of care;</li><li>• use the evidence-base;</li><li>• follow research protocols approved by an ethics board; and/or</li><li>• consult with and follow practices of their peers.</li></ul>	
Infrastructure considerations:			
(1) What are the security and storage requirements?	Observed dosing requires having controlled drugs on site. The CDSA-NCR regulations establish minimum security requirements s for Licensed Dealers: <sup>1</sup> <ul style="list-style-type: none"><li>• Secure area for storage and preparation of the medication that is not accessible to patients or outsiders, including bolted safes, locked narcotic cabinets)</li><li>• Documentation and inventory management systems.</li></ul>	N/A for programs where prescriptions are dispensed at a community pharmacy.  For those that have on-site dispensing but do not observe consumption, see <i>Observed</i> column.	<ul style="list-style-type: none"><li>• Controlled Drugs and Substances Act (CDSA)- Narcotic Control Regulations (NCR),</li><li>• Regulatory Colleges,</li><li>• Provincial/ Territorial Health and Safety Regulations,</li><li>• iOAT guidelines<sup>3</sup>.</li></ul>

**Table 3-2 – Regulatory considerations for observed and unobserved dosing**

Question	Observed	Unobserved	Legislation/ Regulation and Oversight
	<p>In addition, Health Canada has developed guidance for community pharmacists to minimize the potential diversion of controlled substances from their establishments<sup>2</sup>, including:</p> <ul style="list-style-type: none"> <li>• security measures, destruction procedures, inventory and reconciliation, and record-keeping.</li> </ul>		
<b>(2) What other spatial considerations are there?</b>	<p>Consumption and chill out areas:</p> <ul style="list-style-type: none"> <li>• Dedicated room with controlled entry that has space for supervised injection,</li> <li>• Table/bench space with cleanable surface (i.e. not wood),</li> <li>• Seating that is easily moved and cleaned,</li> <li>• Storage area for clients' belongings to prevent diversion,</li> <li>• Comfortable area for post-consumption monitoring.</li> </ul> <p>Storage area for injection equipment.</p>	<p>Storage area for tourniquets, Steri-wipes; filters; needles of various gauges; and other safer injection equipment.</p> <p>Refer clients to supervised consumption services/ overdose prevention services, provide education on safer use practices.</p>	<ul style="list-style-type: none"> <li>• Provincial/territorial health and safety regulations.</li> <li>• iOAT guidelines.</li> <li>• Best practices for harm reduction<sup>4</sup>.</li> </ul>
<b>(3) How are the doses prepared?</b>	<p>For injectables, a pharmacy is required either onsite or in the community that meets professional and jurisdictional requirements for compounding.</p> <p>Onsite preparation requires authorized health practitioners.</p> <p>The question of who crushes and prepares tablets for injection must be addressed. Currently, nurses are only permitted to do this when following an approved research protocol.</p> <p>Monitoring system needed to ensure minimum time between doses.</p>	<p>Doses of injectables are prepared at a compounding pharmacy compliant with jurisdictional regulations.</p> <p>Tablets can be dispensed at a community pharmacy that does not do compounding.</p> <p>Clients prepare their dosage of tablets for consumption (e.g., for injection, inhalation, intranasal use).</p>	<ul style="list-style-type: none"> <li>• CDSA-NCR-New Classes of Practitioner Regulations (NCPR).</li> <li>• Professional regulatory Colleges.</li> </ul>

**Table 3-2 – Regulatory considerations for observed and unobserved dosing**

Question	Observed	Unobserved	Legislation/ Regulation and Oversight
<b>(4) Who administers doses?</b>	<p>Clients administer their own dosages.</p> <p>Under circumstances in which a client cannot inject themselves, nurses may be permitted to administer intramuscular or subcutaneous injections – <i>check with jurisdictional regulatory Colleges.</i></p>	Clients administer their own doses.	<ul style="list-style-type: none"> <li>• CDSA-NCR-NCPR.</li> <li>• Professional regulatory Colleges.</li> </ul>
<b>(5) What staffing requirements are there?</b>	<p>Qualified health professionals or supervised trained staff for pre- and post-assessment, administration of correct dose, and supervision of self-administered injections.</p> <p>Access to qualified health professionals and trained staff 7 days per week, 365 days per year.</p> <p>Support workers, such as peer workers, harm reduction workers, community outreach workers, case managers.</p>	<p>Access to a safer supply prescriber, including a backup to provide continuity of care should primary prescriber be absent.</p> <p>Programs do not need to operate 7 days per week, 365 days per year. Must make sure that the pharmacy has a prescription for days when the program is closed.</p> <p>Support workers, such as harm reduction workers, peer workers, community outreach workers, case managers.</p>	<ul style="list-style-type: none"> <li>• CDSA-NCR-NCPR.</li> <li>• iOAT guidelines (can be adapted for safer supply goals).</li> <li>• Best practices in harm reduction services<sup>5</sup>.</li> </ul>
<b>Other considerations:</b>			
<b>(1) Titration</b>	Observed titration is consistent with observed dosing programs. Not everyone needs a full titration program, however.	Some flexible models permit self-titration, others follow an unobserved titration protocol.	<ul style="list-style-type: none"> <li>• Professional regulatory Colleges.</li> <li>• iOAT guidelines may be adapted for safer supply.</li> </ul>
<b>(2) Dosing schedule</b>	<p>Can offer a fixed dosing schedule or flexible timing with a defined minimum amount of time between doses (e.g., up to 5 times per day, at least 1 hour between doses).</p> <p>Dosing schedules are linked to program hours of operation.</p>	Unobserved dosing provides clients with a flexible dosing schedule, with recommended periods of time between doses. Clients pick up their daily supply and use as needed. Doses are not connected to program hours of operation.	<ul style="list-style-type: none"> <li>• Professional regulatory Colleges.</li> <li>• iOAT guidelines may be adapted for safer supply.</li> </ul>

**Table 3-2 – Regulatory considerations for observed and unobserved dosing**

Question	Observed	Unobserved	Legislation/ Regulation and Oversight
<b>(3) Diversion</b>	<p>Observed dosing is thought to reduce diversion, in conjunction with security procedures (e.g., secure storage, separate area for clients to store belongings).</p> <p>Please see above: <i>Infrastructure considerations #1. Security and storage requirements</i></p>	<p>Diversion concerns are greater for programs with unobserved dosing.</p>	<ul style="list-style-type: none"> <li>• CDSA and NCR</li> <li>• Professional regulatory Colleges</li> <li>• Provincial/Territorial Health and Safety Regulations</li> <li>• iOAT guidelines may be adapted for safer supply</li> </ul>
<b>(4) Individual client needs</b>	<p>Clinical judgment should be used to determine if observed dosing is required, for example, for clients who are also using alcohol or benzodiazepines, who have complex health issues, or who struggle with stability.</p>	<p>Clinical judgment should be used to determine if unobserved dosing is appropriate for clients.</p> <p>Unobserved dosing may support clients' engagement with employment, education, and childcare.</p>	<ul style="list-style-type: none"> <li>• Professional regulatory Colleges.</li> <li>• iOAT guidelines may be adapted for safer supply.</li> </ul>

<sup>1</sup> Health Canada. Directive on Physical Security Requirements for Controlled Substances (Security Requirements for Licensed Dealers for the Storage of Controlled Substances) Retrieved from: <https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/controlled-substances-precursor-chemicals/directive-physical-security-requirements-controlled-substances-licensed-dealers-security-requirements-storage.html>

<sup>2</sup> Health Canada (2019). *Recommended guidance in the areas of security, inventory reconciliation and recordkeeping for community pharmacists*. Retrieved from: [https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists\\_EN.pdf](https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists_EN.pdf)

<sup>3</sup> British Columbia Centre on Substance Use (2017). *Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder*. Retrieved from: <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

<sup>4</sup> Strike C, Hopkins S, Watson TM, Gohil H, Leece P, Young S, Buxton J, Challacombe L, Demel G, Heywood D, Lampkin H, Leonard L, Lebounga Vouma J, Lockie L, Millson P, Morissette C, Nielsen D, Petersen D, Tzemis D, Zurba N. (2013). *Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are at Risk for HIV, HCV, and Other Harms: Part 1*. Toronto, ON: Working Group on Best Practice for Harm Reduction Programs in Canada. Retrieved from: <https://www.catie.ca/en/programming/best-practices-harm-reduction#part1>

<sup>5</sup> Strike C, Watson TM, Gohil H, Miskovic M, Robinson S, Arkell C, Challacombe L, Amlani A, Buxton J, Demel G, Gutiérrez N, Heywood D, Hopkins S, Lampkin H, Leonard L, Lockie L, Millson P, Nielsen D, Petersen D, Young S, Zurba N. (2015). *The Best Practice Recommendations for Canadian Harm Reduction Programs that Provide Service to People Who Use Drugs and Are at Risk for HIV, HCV, and Other Harms: Part 2*. Toronto, ON: Working Group on Best Practice for Harm Reduction Programs in Canada. Retrieved from: <https://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf>

### 3.1.3 Service delivery design considerations for rural and remote areas

Patterns of substance use, the illegal drug market, the availability of services and resources, and socio-cultural responses to substance use may be significantly different in remote and rural areas. Some communities and their leadership may benefit from education about the role of safer supply programs to reduce the harms related to use of illegal drugs. A critical component for the success of a program in some rural and remote communities is gaining the approval and support of leadership, and attending to the cultural and social determinants of health.

Access to harm reduction and primary care services may be more difficult in rural and remote areas. Many rural areas report service shortages that result in significant barriers to care. In resource-scarce areas, the pharmacy-model of iOAT (supervised consumption in a pharmacy, similar to community pharmacy based oral OAT access) and flexible (i.e., unobserved consumption) models may prove most effective.

Some other models to consider, often in conjunction with the pharmacy model or flexible models, include:

**Hub and spoke model:** The hub and spoke model of service delivery arranges service delivery assets into a network consisting of an anchor establishment (hub) that offers a full array of services, complemented by secondary establishments (spokes or satellites) that offer more limited services<sup>1</sup>. Those individuals who require more intensive services attend the hub (e.g., for initial assessment and titration), and ongoing support and services (such as observed consumption) is offered at spoke sites. Spoke sites could offer group appointments, as well as individual follow-up. This works in a similar manner as the pharmacy model, but the spokes would offer broader support and services than that offered by a pharmacy alone. This model may also adopt a mobile component, where the ‘spokes’ are mobile satellites.

**Telehealth:** Telehealth offers a promising tool for providing services in rural areas where there is a lack of specialized providers and services. Telehealth uses technology to provide access to services across distance by connecting clients with providers for screenings, counseling, and other services. Multiple technological platforms are being used: telephones, smart phone applications, and video conferencing, for example. This approach is useful not just for barriers related to distance from providers, but also for privacy concerns, lack of access to transportation, and concerns about missing time from work and childcare. A study<sup>2</sup> of people engaged in opioid agonist therapy across 48 clinics in Ontario found that patients who were treated via telehealth were more likely to be retained in therapy than patients treated in person, and the group that used both telehealth and in person treatment also had higher retention rates than those only receiving care in person. This model may be used alongside the pharmacy-model.

**Mobile services:** Mobile services offer the possibility of bringing services, medications, health professionals to localities where a fixed site could not be sustainably supported. Research<sup>3</sup>

suggests that mobile services mitigate barriers such as distance, social isolation, lack of time, and childcare issues, and are cost-effective ways of improving health outcomes in underserved communities. Mobile services may be used alongside telehealth and pharmacy-models.

**Peer support services:** Trained, employed peer support workers can maintain presence, support, and service provision in areas lacking local health and social services. In addition to filling the service gap, they may also enhance program legitimacy and acceptability. Employing peer workers contributes to their social determinants of health (see Section 4.5) by providing income and employment, and it may expand the reach of services to community members previously unconnected to services. Peer workers from the local community will understand and share cultural similarities that may contribute to greater trust and willingness to engage in services.

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<sup>1</sup> Elrod JK and Fortenberry Jr JL. (2017). The hub-and-spoke organization design: an avenue for serving patients well. *BMC Health Services Research*, 17(Suppl 1):457. <https://doi.org/10.1186/s12913-017-2341-x>

<sup>2</sup> Eibl JK, Gauthier G, Pellegrini D, Daiter J, Varenbut M, Hogenbirk JC, and Marsh DC. (2017). The effectiveness of telemedicine-delivered opioid agonist therapy in a supervised clinical setting. *Drug and Alcohol Dependence*, 176, 133-138. <https://doi.org/10.1016/j.drugalcdep.2017.01.048>

<sup>3</sup> Stephanie W.Y. Yu, Caterina Hill, Mariesa L. Ricks, Jennifer Bennet, and Nancy E. Oriol. (2017). The scope and impact of mobile health clinics in the United States: a literature review. *International Journal for Equity in Health*, 16, 178. [10.1186/s12939-017-0671-2](https://doi.org/10.1186/s12939-017-0671-2)

### 3.1.4 Case study of current safer supply pilot project

#### **Portland Hotel Society (PHS) Molson Overdose Prevention Site program – an example of an Enhanced iOAT model**

##### **TiOAT Program - Tablet Injectable Opioid Agonist Treatment Program**

A treatment program that includes safer supply goals, i.e., the provision of a pharmaceutical opioid to reduce illegal drug use.

PHS has started a program for people with opioid addiction who have not responded well to oral opioid agonist treatments like Methadone, Suboxone®, or Kadian®. The program is located at the Molson Overdose Prevention Site (OPS). The hours are from 1pm-10pm.

**The program:** Participants receive 2 crushed hydromorphone 8 mg tablets to inject or take orally at Molson OPS up to 5 times per day as needed, with 1 hour minimum between doses. There are no take home doses. This is a pilot program and is being evaluated.

##### **To qualify, people must:**

- Be diagnosed with Opioid Use Disorder
- Have tried methadone formulations, Kadian®, or Suboxone® in the past without success
- Be willing to follow up with the doctor and clinical team
- Be willing to sign consent forms

##### **Program rules:**

- Must inject/take at the MOPS
- No mixing with other street drugs (has to be separate hits)
- No jugging or injecting in the groin
- No doctoring (assisted injection)
- Be respectful of clients and staff
- Provide regular urine drug tests

##### **To sign up, people must:**

- Fill out paperwork at MOPS and provide a urine sample.
- See a doctor at MOPS to assess medical eligibility
- Get approved and start (space permitting)



## **3.2 Selecting, Obtaining, and Dispensing Regulated Drugs for Safer Supply Programs**

This section provides information about selecting and obtaining regulated pharmaceutical-grade opioids and stimulants as alternatives to the toxic illegal drug supply. While the decision of which drug may be most appropriate for an individual is made between a prescriber and the client, issues such as accessibility, formulations, cost, compounding and dispensing, and preferences all influence which drugs may be used. This section offers:

- 3.2.1.** A comparison of regulated pharmaceutical-grade opioids used in safer supply programs, including how to obtain them
- 3.2.2.** Information about pharmaceutical-grade stimulants used in safer supply programs
- 3.2.3.** A map of the regulatory landscape for acquiring controlled substances via existing regulations

### 3.2.1 Regulated pharmaceutical opioids used in safer supply programs

A range of regulated pharmaceutical opioids are currently in use across the range of *Enhanced* and *Flexible* models of safer supply. In programs that rely on injectable opioids, diacetylmorphine and hydromorphone are both evidence-based medication choices (based on patient choice and prescriber judgment); however, hydromorphone is most commonly prescribed due to the significant difficulties in accessing a sustainable supply of diacetylmorphine (BCCSU 2017). Considerations related to these two medication options are discussed below, and a summary comparison of different options and their respective regulatory considerations are presented in **Table 3-3**.

#### Access

- Diacetylmorphine is not manufactured domestically, and can be difficult to access because of importation challenges, and insufficient supplies; however, Health Canada has recently added diacetylmorphine (brand name Diaphin I.V.) to the *List of Drugs for Urgent Public Health Need* for severe opioid use disorder (as of April 25, 2019); with this recent listing, practitioners across Canada can now prescribe diacetylmorphine, which has been approved in a foreign jurisdiction, but that is not approved in Canada.
- Health Canada recently (May 1, 2019) approved supervised injectable opioid agonist therapy (sIOAT) as an indication for one brand of injectable hydromorphone (10mg/ml, 20mg/ml, 50mg/ml, and 100mg/ml); however, most provincial formularies only list low-potency hydromorphone (e.g., 10 mg/ml) and hydromorphone tablets, making cost a barrier for some.
- Hydromorphone tablets are available in both brand name (Dilaudid®) and generic. Dilaudid® is preferred by most people who use drugs because it is easier to crush and prepare than generics.

#### Formulation

- Injectable high-potency hydromorphone (e.g., 50mg/ml, 100mg/ml) has been indicated for opioid use disorder, and is the preferred option among stakeholders.
- Medically, higher dosing strengths are preferred as it is always safest to inject lower volumes intravenously.
- Off-label prescribing of hydromorphone tablets for injection is being piloted and evaluated.

#### Compounding & dispensing

- Injectable hydromorphone is dispensed either by single-use ampules delivered by a local pharmacy, or through advanced compounding by a trained pharmacist compliant with jurisdictional professional College requirements.
- Nurses can draw up doses from single-use ampules.
- Single-use ampules come in a limited range of concentrations, making it difficult to provide accurate doses without resulting wastage.
- Advance compounding, which uses multi-use vials, reduces wastage and the potential for diversion; however, the compounding infrastructure requirements may not make this

feasible for organizations without embedded pharmacies, or for community pharmacies that do not meet jurisdictional professional requirements.

- Tablets need to be crushed and, if to be injected, prepared using best practice recommendations, i.e., using high quality pill crusher (e.g., Silent Knight<sup>1</sup>) and filtration using a combination of a Sterifilt® and cotton filter<sup>2</sup>.
- Current pilot projects provide a research protocol that enable nurses to prepare tablets for injection. The issue of who prepares tablets for injections will need to be clarified with professional regulatory colleges and/or through the establishment of safer supply guidelines.

### **Cost**

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- Most provincial formularies only list low-potency hydromorphone (e.g., 10 mg/ml), and programs have found that clients require very large volumes to meet their optimal dosage, or to use tablets.
- There are considerable differences in costs for prescription drugs depending upon who is purchasing. Hospitals are able to negotiate purchase agreements, and so are able to purchase at much lower rates than community pharmacists.
- Multi-dose vials requiring advanced compounding are often cheaper, and reduce wastage and the potential for diversion; however, this option is not available to those sites that lack an on-site pharmacy, unless they have health care professionals on site whose provincial regulations permit compounding.

### **Health risks**

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- Oral hydromorphone tablets (that are then crushed, prepared, and injected) are considerably cheaper than injectable hydromorphone; however, regulatory Colleges have expressed concerns about injecting a drug that is intended for oral consumption only, due to unclear health risks, though studies<sup>9</sup> are now suggesting that combined filtration using Sterifilt® filter and cotton filter is an effective harm reduction practice (see **Section 2: Review of the evidence**).
- People who inject hydromorphone tablets report a preference for Dilauid® (name brand) over generic tablets, saying that the Dilauid® is easier to crush and prepare. Immediate release tablets are preferred to extended release tablets. Extended release tablets have a waxy coating and often produce a jelly-substance, which may increase health risks of injecting these tablets compared to Dilauid®.
- There are preferred types of equipment for preparing tablets for injection: a pill crusher and filters that are being piloted to see if in controlled environments, injection of tablets is not as risky as previously thought (e.g., risks of endocarditis, abscesses, vein damage).

### **Diversion**

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There are concerns that oral tablets are more easily diverted. A current Vancouver-based pilot study of an observed tablet injection program requires nurses to crush and prepare the tablets for injection and add 8-10 drops of sterile water to moisten the powder (to prevent diversion), as per the research protocol. As stated above, the issue of who prepares tablets for injection

must be addressed through the establishment of guidelines, and/or by professional regulatory colleges.

**Obtaining hydromorphone** (*the following information is adapted from the BC iOAT Guidelines 2017*)

There are two ways of obtaining hydromorphone: either through advanced compounding and preparation of doses in a pharmacy compliant with jurisdictional professional requirements, or via delivery of single-use vials by a local pharmacy. Doses prepared using advanced compounding allow for a beyond-use date of up to nine days if the syringes are refrigerated, and up to thirty hours if at room temperature. Hydromorphone 50mg/ml is available in single use vials. Best practices and established standards for preparing and handling injections must be followed. For information about preparing injections and prescribing injectable hydromorphone, please see:

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

Canadian Research Initiative in Substance Misuse (CRISM). (Not yet published). *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline*.

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<sup>1</sup> Silent Knight pill crusher: [http://shop.gohcl.com/Customer/hecalo/specpages/7423-01\\_Instructions.pdf](http://shop.gohcl.com/Customer/hecalo/specpages/7423-01_Instructions.pdf)

<sup>2</sup> Noël L., Dubé P.-A., Tremblay, P.-Y., et Groupe de travail sur la révision du matériel d'injection destiné aux personnes UDI. (2015). *Matériel d'injection: réduire les risques chez les injecteurs de médicaments opioïdes*. Québec, Institut national de santé publique du Québec.

**Table 3-3 – Obtaining opioids: navigating the regulatory landscape**

Question	Diacetylmorphine (DAM)	Hydromorphone (HDM Injectable)	Hydromorphone tablets (HDM)	Legislation/ Regulation and Oversight
<b>Is it legal for use in Canada and indicated for Opioid Use Disorder (OUD)?</b>	Yes. It is currently on <i>List of Drugs for an Urgent Public Health Need</i> for OUD in all jurisdictions across Canada.	Yes. Injectable hydromorphone at low and high potency are indicated for OUD.	No. Hydromorphone tablets are not indicated for OUD. They are used off-label.	<ul style="list-style-type: none"> <li>Controlled Drugs and Substances Act (CDSA) and Narcotic Control Regulations (NCR).</li> <li><i>Food and Drugs Act (FDA) and Food and Drug Regulations (FDR).</i></li> </ul>
<b>Is it produced in Canada?</b>	No	Yes	Yes	<ul style="list-style-type: none"> <li>CDSA-NCR</li> <li>FDA and FDR</li> </ul>
<b>Is it covered under most provincial formularies?</b>	No. Individuals can apply for coverage under provincial cost coverage programs.	<p>No. High potency hydromorphone is not covered by most provincial formularies. Individuals can apply to provincial cost coverage programs.</p> <p>Yes. Lower potency (e.g., 10mg/ml) is covered.</p>	<p>Yes. There may be caps or limits on quantities covered.</p> <p>Not indicated for injection, or for OUD.</p>	<ul style="list-style-type: none"> <li>Provincial legislation.</li> </ul>
<b>Who can prescribe it?</b>	Doctors and nurse practitioners trained in prescribing for OUD.		Doctors and nurse practitioners. (Requirements for training in prescribing for OUD may vary by jurisdiction).	<ul style="list-style-type: none"> <li>CDSA-NCR,</li> <li>Professional regulatory Colleges.</li> </ul>
<b>Prescription requirements</b>	Requires a written order or prescription that is signed and dated by a practitioner and the signature of the practitioner, if not known to the pharmacist, has been verified by the pharmacist.			<ul style="list-style-type: none"> <li>CDSA – NCR.</li> </ul>
<b>Transport and storage</b>	<ul style="list-style-type: none"> <li>Depending on the jurisdiction, a nurse practitioner/nurse may transport controlled substances</li> <li>Storage requirements for Licensed Dealers are the same for all narcotics as laid out in <i>Security Requirements for Licensed Dealers for the Storage of Controlled Substances</i> (includes: bolted safe, inventory management, etc.) <ul style="list-style-type: none"> <li>See: <a href="https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/controlled-substances-precursor-chemicals/directive-physical-security-requirements-controlled-substances-licensed-dealers-security-requirements-storage.html">https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/controlled-substances-precursor-chemicals/directive-physical-security-requirements-controlled-substances-licensed-dealers-security-requirements-storage.html</a></li> </ul> </li> <li>Health Canada has developed guidance<sup>1</sup> for community pharmacists to minimize the potential diversion of controlled substances from their establishments, including: security measures, destruction procedures, inventory and reconciliation, and record-keeping.</li> </ul>			<ul style="list-style-type: none"> <li>Professional regulatory Colleges,</li> <li>CDSA-NCR, NCPR.</li> </ul>

**Table 3-3 – Obtaining opioids: navigating the regulatory landscape**

Question	Diacetylmorphine (DAM)	Hydromorphone (HDM Injectable)	Hydromorphone tablets (HDM)	Legislation/ Regulation and Oversight
<b>Compounding requirements</b>	Yes. Requires a compounding pharmacy that is compliant with jurisdictional professional requirements.	Yes. For advance compounding, the pharmacy must be compliant with jurisdictional professional requirements for compounding. Check with jurisdictional college to see if nurses can compound on site.	N/A	<ul style="list-style-type: none"> <li>Professional regulatory Colleges (nursing, pharmacy).</li> </ul> <p>Note: The National Association of Pharmacy Regulatory Associations (NAPRA) provides model standards for compounding, but requirements are established and enforced by provincial Colleges. Requirements may be based on NAPRA's model standards.</p>
<b>Who can prepare doses?</b>	Trained pharmacists working in pharmacies that are compliant with jurisdictional professional requirements for compounding. Nurses can prepare doses from single use ampules according to jurisdictional College regulations.		It's complicated.  Current standards of practice do not support the prescription of tablets for injection. Research protocols may provide a way for nurses to prepare pills for injection by crushing them and providing Sterifilt® and cotton filters.	<ul style="list-style-type: none"> <li>Professional regulatory Colleges</li> </ul>
<b>Who can administer doses?</b>	Health practitioners.  Varies by jurisdiction May only permit intramuscular or subcutaneous injection, or not at all.	Health practitioners  May vary by jurisdiction. May only permit nurses to inject intramuscular or subcutaneous, or not at all.	<i>See above.</i> Use of pills for injection is not currently supported by professional Colleges.	<ul style="list-style-type: none"> <li>Professional regulatory Colleges</li> </ul>

**Table 3-3 – Obtaining opioids: navigating the regulatory landscape**

Question	Diacetylmorphine (DAM)	Hydromorphone (HDM Injectable)	Hydromorphone tablets (HDM)	Legislation/ Regulation and Oversight
<b>Stakeholder Perspectives</b>	<p><b>Service providers:</b> Very interested because it has been found to be superior to methadone<sup>2</sup> but too many regulatory and supply concerns.</p> <p><b>PWUD:</b> Very interested.</p>	<p><b>Service providers:</b> Hydromorphone is seen to be non-inferior to diacetylmorphine<sup>3</sup>. Higher confidence than tablets; concern about volume needed when only 10mg/ml is listed on formularies.</p> <p><b>PWUD:</b> Very interested.</p>	<p><b>Service Providers:</b> Colleges have regulatory concerns (crushing tablets for injection); concern with number of tablets required to match doses needed; diversion concerns.</p> <p><b>PWUD:</b> Report a preference for name brand Dilaudid® because they say that generic does not cook the same way and it provides a different high.</p>	

<sup>1</sup> Health Canada (2019). Recommended guidance in the areas of security, inventory reconciliation and recordkeeping for community pharmacists. Retrieved from: [https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists\\_EN.pdf](https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists_EN.pdf)

<sup>2</sup> See *Section 2: Review of the evidence*

<sup>3</sup> Oviedo-Joekes E, Guh D, Brissette S, Marchand K, Macdonald S, Lock K, et al. (2016). Hydromorphone Compared With Diacetylmorphine for Long-term Opioid Dependence. *JAMA Psychiatry*, 73(5), 447–9.

### ***3.2.2 Regulated pharmaceutical stimulants used in safer supply programs***

The Safer Supply Implementation Task Team also discussed the need for regulated alternatives for people who use stimulants such as cocaine, crack cocaine, and crystal methamphetamine. While the research on safer supply stimulant programs is not as robust as the research on oral or injectable opioid agonist treatments, there is increasing interest in the use of pharmaceutical stimulants as substitution therapy.

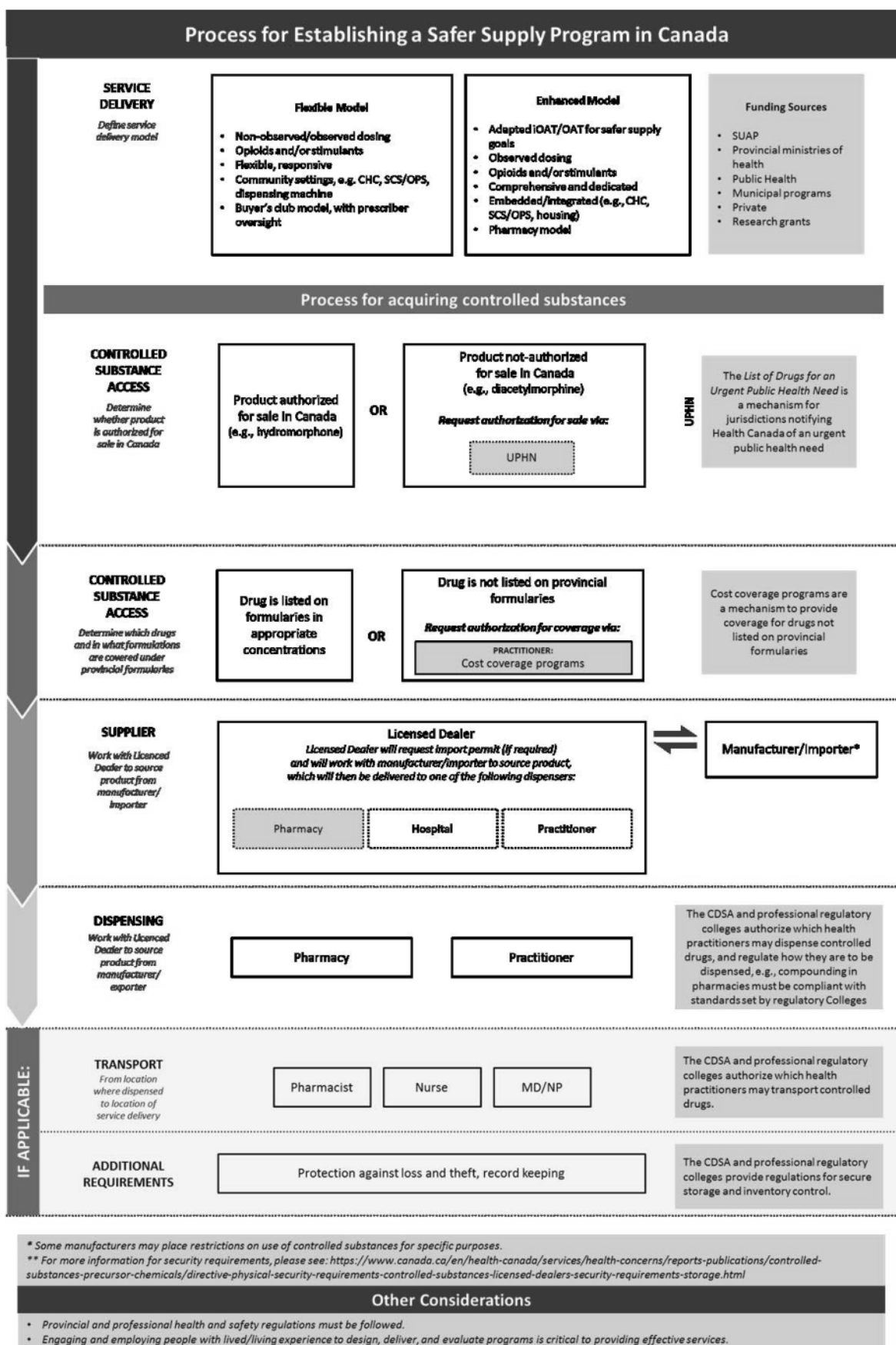
People may use stimulants on their own, or together with opioids. The culture of stimulant use, in which stimulants are smoked or injected, and in which use is often concentrated into intensive binges, is not as easily replicable in safer stimulant programs.

Polysubstance use is also common: opioids can help someone who has been using stimulants come down more gently, and stimulants can help those using opioids stay awake and aware to enjoy their high. These patterns of use, and the dependence on the illegal drug supply, should be considered when designing safer supply programs. Consulting with people who use drugs will help to identify which drugs are being used and how, and this can inform decisions about prescribing stimulants, including formulations.

Examples of pharmaceutical drugs that are currently being prescribed off-label as stimulant substitution treatment include Vyvanse (lisdexamfetamine dimesylate), Adderall, Dexedrine, methylphenidate, and modafinil. These are covered under most formularies.



### 3.2.3 Map of the regulatory landscape for acquiring controlled substances



### 3.3 Considerations for Operational and Clinical Protocols and Policies

There are several guiding documents now available that can be used as templates for protocols and policies, including both operational considerations and clinical guidance. The following iOAT guidelines can be adapted for safer supply programs:

British Columbia Centre on Substance Use (2017) **Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder**. Available at: <http://www.bccsu.ca/wp-content/uploads/2017/10/BC-iOAT-Guidelines-10.2017.pdf>

Canadian Research Initiative in Substance Misuse (CRISM). National Injectable Opioid Agonist Treatment for Opioid Use Disorder Operational Guidance. [not yet published]. Available at: <https://crism.ca/projects/ioat-guideline/>

#### 3.3.1 Operational policies

The following list is meant to identify different facets of safer supply program operations that require policy and protocol development.

##### A. Eligibility

- a. Eligibility criteria
- b. Eligibility assessment

Programs should define the target population and eligibility criteria, including factors such as level of risk, stability, age, substance use, and connection to programs and services. In addition to defining eligibility criteria, policies should be developed regarding how criteria will be assessed.

##### B. Medical assessments

- a. Prescriber (i.e., nurse practitioner or physician) assessment
- b. Nursing assessment

In addition to assessing program eligibility, potential clients should be medically assessed using clinical assessment tools.

##### C. Rights and Responsibilities of Clients and Service Agreements

Clients' rights and responsibilities and general rules for accessing services must be clearly defined. Service agreements may contain standard rights and responsibilities that apply to all clients at all times, including expectations of privacy according to provincial health privacy laws, confidentiality, and the right to be treated with respect and dignity. Service agreements may also be individualized plans of care, including agreements negotiated between service providers and clients for specific situations, such as "carries" privileges.

**D. General responsibilities and rules for all staff**

Policies and procedures, expectations and responsibilities must be clearly defined for all staff, including a defined schedule for regular review and revision of policies.

- a. Protocols for data collection and documentation
- b. Maintaining clean and safe space protocols
- c. Access and Security policies
- d. Protocols for assessing intoxicated individuals
- e. Policies about conditions for refusing service
- f. Policies for providing referrals to additional services
- g. Crisis and conflict intervention policies
- h. Security protocols and procedures
- i. Occupational health and safety protocols

**E. Models with on-site dispensing and consumption must include policies to address regulatory requirements, such as:**

- a. Medication storage protocols
- b. Medication preparation and administration protocols
- c. Monitoring Injections/witnessed doses policy and procedure
- d. Policies for designated assistance with injection, including consent forms to be signed by both client and the designated assistant
- e. Injection equipment disposal
- f. Infection control policies
- g. Opioid intoxication assessment and procedure
- h. Protocols for overdoses and medical emergencies
- i. Policies to reduce risk of diversion:
  - Medication and injection counts, narcotic control policies (receiving, returning, preparing, dispensing, waste)
  - Witnessed dosing (in person or by camera)
  - For tablets to be injected, moisten crushed/powdered tablets by adding 8-10 drops of sterile water to crushed/powdered tablets
  - For tablets to be ingested, add crushed/powdered tablets to apple sauce or pudding
  - For providing slow-release oral morphine (Kadian®), open capsules and put beads in pudding/water
  - No personal belongings in the consumption space
  - General monitoring of all clients

**F. General security**

Protocols, policies, and procedures are needed for:

- a. Property security
- b. Client and staff health and safety
- c. Managing challenging behaviours
- d. Responding to emergencies

### 3.3.2 Clinical protocols

Clinical protocols are required and must be developed according to regulatory guidelines and requirements, professional standards of care, best practices, research protocols approved by ethics boards, and emerging evidence-informed practice.

There are two guiding documents for clinical protocols for supervised injection opioid agonist treatment (iOAT). These are:

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

Canadian Research Initiative in Substance Misuse (CRISM). (Not yet published) *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline.* Retrieved from: <https://crism.ca/projects/ioat-guideline/>

Clinical protocols commonly include, but are not limited to, the following:

1. Obtaining, storing, and disposing of medications
2. Medical eligibility assessment
3. Health assessments and nursing care
4. Selection of dose
5. Initiation and re-initiation protocols, including titration protocols and dosing schedules.
6. Co-prescription of oral OAT
7. Dosage equivalents with oral methadone and slow-release oral morphine (SROM – Kadian®)
8. Clinical protocols for people who are pregnant or could become pregnant
9. Urine drug testing protocols (if needed)
10. Protocols for “carries”, absences, and missed doses
11. Overdose medical directives
12. Non-overdose medical directives
13. Management of seizures
14. Management of chest pain
15. Management of anaphylaxis
16. Protocol for soft tissue care
17. Providing additional health services
18. De-intensification, transition to oral OAT, and discontinuation protocols.

19. Transitions: hospitalization, other.
20. Letter to hospital explaining clients' engagement in a safer supply program
21. Continuity of care

**In addition to the above, models with on-site dispensing and consumption require the additional clinical protocols:**

1. Purchasing and transporting hydromorphone or diacetylmorphine – including delivery and reconciliation policies<sup>1</sup>;
2. Preparing hydromorphone or diacetylmorphine (must be in accordance with college requirements);
3. Pre-injection assessment and post-injection assessments
  - The (modified) Pasero Opioid-induced Sedation Scale (POSS) is a clinical intoxication assessment tool
4. Health care provider administration of injection (must be in accordance with College requirements);
5. Supervision of injections; and
6. Research protocols need to build in flexibility or a trial protocol to allow for adjustments in dosages to determine the optimal dosages.

*Providence Health Care Crosstown Clinic* provides the following order sets:

1. Medication orders
2. Titration orders for high dose hydromorphone
3. Accelerated titration orders for high dose hydromorphone
4. Missed days protocol for post-initiation dose of high dose hydromorphone
5. Titration orders for diacetylmorphine
6. Missed days orders for post-initiation dose of diacetylmorphine

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<sup>1</sup> Community pharmacists may wish to consult the following document for guidance on security measures, destruction procedures, inventory and reconciliation, and record-keeping: Health Canada (2019). Recommended guidance in the areas of security, inventory reconciliation and recordkeeping for community pharmacists. Retrieved from: [https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists\\_EN.pdf](https://napra.ca/sites/default/files/2019-04/CS-GD-022%20Recommended%20guidance%20for%20community%20pharmacists_EN.pdf)

### 3.4 Site requirements and staffing considerations

All models require:

- An assessment and treatment room to be used by physicians, nurse practitioners, and nurses for assessment and enrollment, and program staff for interviews and support;
- A comfortable, welcoming waiting area for clients;
- Space to store a wide range of sterile supplies, equipment, and kits;
- Education, information, resource materials;
- Secure sharps disposal containers;
- Overdose assessment and management equipment: naloxone and related supplies; breathalyzer, pulse oximeter, blood pressure monitor, oxygen, and bag valve mask; and
- Infrastructure for medical records and client files (electronic or other).

Models that provide dispensing and observed dosing require the additional considerations:

- Controlled entry to supervised consumption room (including staff accompaniment);
- Space for clients to store their belongings outside of the consumption area;
- A consumption/witnessing room: comfortable, clean, safe; for supervised consumption; equipped with stainless steel table, chair, secure sharps container, hand sanitizer, antiseptic cleaning wipes, paper towel dispenser, sterile injection equipment; and
- A post-consumption “chill-out” room for monitoring clients.

*In compliance with CDSA standards and their jurisdictions’ regulatory bodies, appropriate storage (i.e., a bolted safe [TRTL15 or TRTL30]), supplies, documentation, and inventory management for the storage, preparation, and disposal of drugs. For more information on storage security, please see: Directive on Physical Security Requirements for Controlled Substances (Security Requirements for Licensed Dealers for the Storage of Controlled Substances), available at:*

<https://www.canada.ca/en/health-canada/services/health-concerns/reports-publications/controlled-substances-precursor-chemicals/directive-physical-security-requirements-controlled-substances-licensed-dealers-security-requirements-storage.html>

#### Staffing Considerations

Staffing models, including the roles and number of staff required during program operating hours will depend on the model of safer supply program, and the number of clients enrolled. However, there are several key activities and responsibilities that must be considered and planned for, and tasked to appropriately trained and qualified staff. These may include:

- Client intake, orientation, and education;
- Ongoing support and service navigation (including providing or referring to additional health care and social services); and
- Medical assessments and nursing care.

In addition to the professionally trained health professionals, people who use drugs should also be involved and employed in the delivery of services, whenever possible (please see **Section 4.5**).

All staff must be properly trained as appropriate to their role and responsibility, including organizational and program policies, protocols, and procedures; training in anti-oppression practices, trauma informed practice, harm reduction, non-violent conflict resolution and strategies for creating a welcoming, non-judgmental environment.

**Table 3-4 – Operational requirements (adapted from BC iOAT Guidelines 2017)**

Flexible models (unobserved dosing)	Comprehensive and dedicated iOAT model	Integrated iOAT Model (CHC, SCS, Housing)	Pharmacy based model	Requirements
				<b>Injection area</b>
N/A	X	X	X	Private room with space for supervised injection
	X	X	X	Table/bench space with cleanable surface (i.e. not wood)
	X	X	X	Seating that is easily moved and cleaned
	X	X		Storage area for clients' belongings to prevent diversion
				<b>Storage and preparation</b>
X	X	X	X	Storage area for tourniquets, Steri-wipes; and needles of various gauges
	X	X	X	Secure area for storage and preparation of the medication that is not accessible to patients or outsiders
	X	X	X	Drug log tracking vials in and out, batch numbers, dose used, and disposal of any unused medication
				<b>Safety</b>
Syringe disposal containers	X	X	X	Syringe disposal that enables syringes to be examined and counted prior to being placed in destruction container
	X	X	X	Access to electronic recordkeeping method to record each prescription, dose, time and variances
	X	X	X	Monitoring system to ensure minimum of 3 hours between doses
X	X	X	X	Resuscitation equipment
X	X	X	X	Take home naloxone
				<b>Compounding pharmacy requirements</b>
X	X	X	X	To compound hydromorphone, pharmacies must comply with standards of practice set by the regulatory college. These are often modelled after NAPRA's <i>Model Standards for Compounding of Non-Hazardous Sterile Preparations</i>
				<b>Staffing model</b>
	X	X	X	Qualified health professionals or supervised trained staff for pre- and post-assessment, administration of correct dose, and supervision of self-administered injections
			X	All pharmacy staff must be trained to follow the policies and procedures in place, including clinical procedures if pharmacy is acting as a clinic



**Table 3-4 – Operational requirements (adapted from BC iOAT Guidelines 2017)**

Flexible models (unobserved dosing)	Comprehensive and dedicated iOAT model	Integrated iOAT Model (CHC, SCS, Housing)	Pharmacy based model	Requirements
			X	A minimum of two pharmacy staff must be available at all times to ensure an adequate response in the event of an overdose
	X	X	X	Access to qualified health professionals and trained staff 7 days per week, 365 days per year
X	X	X	X	Access to continuity of care through prescriber coverage when primary prescriber is away/unavailable
	X	X	X	Hours of operation must allow a minimum of 3 hours between dosing (i.e., up to a 12-hour shift)
X	X	X		Peer workers and or allied health worker for support and connection to community agencies and services
				<b>Security considerations</b>
	X	X	X	Supervision of self-administered injections to observe for diversion
	X	X	X	Narcotic security tailored to setting and capacity (e.g., safe for storage in community, locked narcotic cupboard)
			X	Bolted down time-lock safes
			X	Maintenance of Daily Perpetual Inventory accounting for every milligram produced, wasted, lost in production, dispensed, pre-wasted, unused, waiting for destruction, and destroyed
			X	Monthly reports accounting for daily count of above to ensure proper reconciliation
	X	X	X	Controlled entry into injection room (including simple accompaniment from staff member)
	X	X	X	Syringes must be accounted for post-injection and prior to client leaving facility
	X	X	X	Syringe labeling requirements of relevant regulatory bodies should be followed

# Section 4

## Addressing the Social Determinants of Health

## 4. Addressing the Social Determinants of Health

There are numerous complex factors that influence the initiation and continuation of substance use, including individual, social, cultural, economic, political and socio-structural contexts. These factors are often referred to as the *social determinants of health*, and they account for the ways in which some people who use substances experience extreme marginalization, both due of their substance use and to its intersection with multiple other factors including poverty, criminalization, housing instability or homelessness, food insecurity, gender, race, and experiences of colonialism<sup>1</sup>.

Programs for people who use drugs need to consider ways of addressing broader social determinants of health, such as food, income, social inclusion, housing, and social supports. In this section, we suggest ways safer supply programs can address social determinants of health, such as:

- 4.1 Considerations for designing low-threshold programs
- 4.2 Providing trauma-informed care
- 4.3 Considerations for working with specific populations
- 4.4 Providing continuity of care and wrap-around care
- 4.5 Engaging and employing people who use drugs

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<sup>1</sup> Galea S., Nandi A., Vlahov D. (2004). The Social epidemiology of substance use. *Epidemiologic Reviews*, 26(1):36-52. [doi.org/10.1093/epirev/mxh007](https://doi.org/10.1093/epirev/mxh007)

## 4.1 Designing low-threshold safer supply programs

Offering low-threshold services is a key feature of harm reduction programming and an important characteristic for safer supply programs. Islam et al.<sup>1</sup> suggest that there are three criteria for services to be considered low-threshold: that people who use drugs are the key target population, that abstinence is not required, and that barriers to service access must be reduced as much as possible. Barriers arise when services are not tailored to meet the needs of the population being served. Some specific ways that barriers arise include:

- Employing service limitations or restrictions and other punitive measures to respond to problematic behaviours;
- Providing services only through set scheduled appointments;
- Offering service in narrow windows of time and operating with restrictive hours; and
- Costs associated with services, e.g., costs of prescription medications.

### Ways to make services low-threshold

- Consult with clients and co-write program rules, responsibilities, and expectations, including program hours of operation. This can increase buy-in, and establish expectations that are understandable and acceptable to clients, while also ensuring that the organization is providing services that are meeting the needs of clients.
- Ensure that policies, including responsibilities, expectations, and rules, are well communicated and understood. Consider collaboratively writing with individual clients their own 'service agreements' (also referred to as 'behaviour agreements', 'care plans') to reinforce expectations and ensure their understanding of expectations.
- Provide regulated drugs free of charge.
- Offer as many drop-in programs and drop-in group appointments as possible.
- Focus on engagement between clients and staff. Prioritize the building of relationships and the nurturing of a safe, non-judgmental, welcoming space.
- Encourage people to keep coming back, and make sure to find ways of keeping the door open to them.
- Look at ways of designing spaces and working with people that feel less clinical.
- Assist clients with applications for any income benefits for which they may be eligible, e.g., drug benefits, travel allowance for attending medical appointments and/or programs.

- Use skills such as motivational interviewing, flexibility, and adaptability, and engage with clients without expectations or requirements for them to change. The focus is always on meeting the client where they are at.
- Respond to conflict and problematic behaviours using non-violent crisis intervention and restorative justice approaches.
- For models that have on-site consumption spaces (SCS, OPS, CTS) and witnessing rooms, consider permitting clients to use more than one substance. Many people who use drugs use more than one drug at a time, such as using both a stimulant and an opioid. When appropriate and necessary, engage in conversation with the client about the potential risks of polysubstance use, offer test strips so that they can test an illegal drug, and support them to use as safely as possible.
- Staff should receive appropriate training, supervision, and support to prevent burn-out that can result in reactive responses.

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<sup>1</sup> Islam, M. M., Topp, L., Conigrave, K. M., White, A., Haber, P. S., & Day, C. A. (2013). Are primary health care centres that target injecting drug users attracting and serving the clients they are designed for? A case study from Sydney, Australia. *International Journal of Drug Policy*, 24(4), 326-332. doi:10.1016/j.drugpo.2012.06.002

## 4.2 Trauma informed practice

Past, continuous, and current experiences of trauma are frequent amongst those who struggle with substance use issues. Studies suggest that people with substance use disorders have higher rates of past trauma and comorbid post-traumatic stress disorder compared to the general population<sup>1</sup>. Trauma-informed practice recognizes the impact of trauma in the lives of clients, and seeks to avoid re-traumatizing individuals, and support safety, choice, and control to promote healing<sup>2</sup>. Trauma-informed practice is centred on six core principles<sup>3</sup>:

- Safety
- Trustworthiness and transparency
- Collaboration
- Empowerment
- Choice
- Intersectionality

Organizational and program policies and procedures can be designed with these principles in mind. The following resources, recommended in the CRISM National iOAT Guidelines (2019), provide guidance in how to work from a trauma-informed approach:

Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers*. Vancouver, BC: Centre of Excellence for Women's Health. Retrieved from: [http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide\\_May-2018.pdf](http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf)

Canadian Centre on Substance Use. (2012). *Essentials of Trauma-informed Care*. Retrieved from: <http://bccewh.bc.ca/wp-content/uploads/2014/05/PT-Trauma-informed-Care-2012-01-en.pdf>

Klinic Community Health Centre. (2013). *Trauma-Informed: the Trauma Toolkit, Second Edition*. Retrieved from: [https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed\\_Toolkit.pdf](https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf)

<sup>1</sup> Grant BF, Saha TD, Ruan WJ, et al. (2016). Epidemiology of DSM-5 Drug Use Disorder: Results From the National Epidemiologic Survey on Alcohol and Related Conditions-III. *JAMA Psychiatry*, 73(1), 39-47. 10.1001/jamapsychiatry.2015.2132

<sup>2</sup> Nathoo, T., Poole, N. and Schmidt, R. (2018). *Trauma-Informed Practice and the Opioid Crisis: A Discussion Guide for Health Care and Social Service Providers*. Vancouver, BC: Centre of Excellence for Women's Health. Retrieved from: [http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide\\_May-2018.pdf](http://bccewh.bc.ca/wp-content/uploads/2018/06/Opioid-TIP-Guide_May-2018.pdf)

<sup>3</sup> Bowen, Elizabeth A and Shaanta Murshid, Nadine. (2016). Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy. *American Journal of Public Health*, 106(2), 223-229. Retrieved from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4815621/>

## 4.3 Continuity of Care and Wrap-around Care

### 4.3.1 *Continuity of care*

The needs and goals of clients of safer supply programs may change over time, and programs and services must be able to respond accordingly. Changes may involve intensifying care (e.g., moving to observed dosing) or de-intensifying care (e.g., move to unobserved dosing), or re-initiating care as needed, based on clinical judgment and in collaborative discussion with individual clients.

Policies should be in place to ensure that clients' access to prescribed regulated alternatives is not interrupted or discontinued without their consent. This includes policies for transitioning clients to other prescribers, and policies to address periods of travel, hospitalization or incarceration.

When and where possible, explore ways of flagging people as clients of safer supply programs. In some areas, this may be done through healthcare databases that would automatically notify hospitals and incarceration facilities that clients are receiving ongoing care from specific organizations that includes the provision of regulated substances as alternatives to the illegal market. Some programs issue clients photo identification cards that indicate that they are clients of safer supply programs. These can be shown to police, emergency room personnel, or others to ensure ongoing access to their prescribed pharmaceutical alternatives and any other medications (including oral opioid agonist treatment).

In addition to the above, organizations offering safer supply programs should engage in outreach to community members, such as police, jails, and hospitals, to inform them of the program, what it entails, how to support clients of the program, and how to get in touch with the safer supply program staff to discuss continuity of care. Organizations providing safer supply services should keep police informed about the program, including any changes to services.

### 4.3.2 *Wrap-around care, pathways to care, and accessing additional services*

Wrap-around care refers to intensive case management used to provide coordinated and comprehensive care. The literature on the provision of case management to people who use drugs, particularly people who use drugs and/or have mental health challenges and are experiencing homelessness, generally shows some positive effects on quality of life, and access to specific health services<sup>1</sup>. A more recent systematic review also provides support for case management improving health outcomes for a variety of different groups of people, including people who use drugs and people with mental health challenges<sup>2</sup>. Studies of case management within supportive housing, including of Housing First models where housing is provided with

case management support, have also found it generally effective for people who use drugs<sup>3 4</sup>. All of this supports the provision of comprehensive case management, regardless of the exact nature of the population or the setting in which it is delivered.

A particularly good model for providing wrap-around care has been developing in Toronto<sup>5</sup>. In this model, targeted towards working with people with hepatitis C, teams of primary health care providers, specialists in hepatitis C treatment, case managers and workers with lived experience provide holistic, wrap-around care for a population of people who often continue to use drugs. The program is demonstrating positive outcomes for hepatitis C treatment adherence and completion, as well as increasing engagement, social inclusion, and addressing other social determinants of health<sup>6</sup>. This model is particularly appealing as it provides comprehensive services directly within the agencies that are already providing harm reduction programs, allowing for trust to be built rapidly with people who use drugs. Safer supply programs could adopt this model to expand service delivery to people who use drugs and have complex care needs.

Pathways to care refer to the collaborative provision of comprehensive services established through partnerships with a range of community organizations. Safer supply programs should invest in developing pathways to care with community organizations, in order to streamline referral processes to ancillary services in the community, such as mental health care, housing support, primary care, and substance use treatment. This is particularly important for those programs that are not embedded in organizations with more comprehensive ancillary services. Additional services for clients of safer supply programs may include access to:

- Comprehensive case management/wrap-around care
- Primary care services
- Chronic pain management
- HIV/Hepatitis C care and support
- Mental health services
- Podiatry
- Housing support
- Home care support (assistance with activities of daily living)
- Income support
- Drop-in programs
- Employment and vocational training
- Substance use treatment and recovery services
- Dental care
- Nutrition care
- Social recreational programs
- Group appointments



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<sup>1</sup> Hwang SW, Tolomiczenko G, Kouyoumdjian FG, Garner RE. (2005). Interventions to improve the health of the homeless: a systematic review. *American Journal of Preventive Medicine*, 29(4), 311–9.

<sup>2</sup> Hwang, S. et al. (2014). Homelessness 2 Health interventions for people who are homeless. *Lancet*, 384(9953), 1541–7.

<sup>3</sup> Rog DJ, Marshall T, Dougherty RH, George P, Daniels AS, Ghose SS, et al. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services*, 65(3), 287–94.

<sup>4</sup> Urbanoski K, Veldhuizen S, Krausz M, Schutz C, Somers JM, Kirst M, et al. (2017). Effects of comorbid substance use disorders on outcomes in a Housing First intervention for homeless people with mental illness. *Addiction*, 113(1), 137–45

<sup>5</sup> Mason K, Dodd Z, Sockalingam S, Altenberg J, Meaney C, Millson P, et al. (2015). Beyond viral response: A prospective evaluation of a community-based, multi-disciplinary, peer-driven model of HCV treatment and support. *International Journal of Drug Policy*, 26(10), 1007–13.

<sup>6</sup> Sockalingam S, Blank D, Banga CA, Mason K, Dodd Z, Powis J. (2013). A novel program for treating patients with trimorbidity: hepatitis C, serious mental illness, and active substance use. *European Journal of Gastroenterology & Hepatology*, 25(12), 1377–84.

## 4.4 Considerations for Working with Specific Populations

### **Marginalization and the social determinants of health**

The social determinants of health account for the ways in which some people who use substances experience extreme marginalization, both due of their substance use and to its intersection with multiple other factors including poverty, housing instability or homelessness, food insecurity, gender, race, experiences of colonialism and criminalization<sup>1</sup>. These factors can have a strong influence on health, and the intersection of these factors can greatly affect the availability of resources and access to health and social services for people who use drugs, thereby creating a major health equity issue<sup>2</sup>.

Attention must be paid to the social determinants of health, as well as power-imbalances that exist between service providers and service users. Many people who have experienced marginalization have faced discrimination, violence, and barriers to accessing services. As such, establishing safety is an essential element to working with people who have experienced marginalization. Safer supply programs must be welcoming, non-judgemental spaces, in which physical, emotional, and cultural safety is nurtured. There are many ways of working towards providing such a space, including appropriate training for all staff (including support staff), tailoring the program to particular populations where possible, and ensuring that all referrals are to appropriate services. Below are some considerations for working with specific populations, including women, youth, First Nations and Indigenous peoples, and LGBT2Q+ individuals.

### **Women**

Women, particularly those who are street-involved, are at high risk of overdose and are particularly affected by the intersection of forms of marginalization, thereby exacerbating risks of harm and increasing vulnerability. Studies show that in comparison to men, women starting iOAT have higher rates of HIV and hepatitis C infections, cocaine use, experiences of physical and sexual abuse, suicide attempts, involvement with sex work, and lower rates of employment<sup>3 4</sup>. A recent study<sup>5</sup> of an overdose prevention site in Vancouver BC found that services designated as 'gender-neutral' were often experienced as 'masculine' by women, and a site where they were confronted with harassment from men. Given these reasons, women-only services, spaces, or hours should be offered, whenever possible, and referrals to ancillary services would be ideally to services specialized for women.

## Youth

It is well established that youth and young adults are amongst those at risk of overdose and other harms related to using toxic illegal drugs, and that youth face significant barriers to accessing addiction treatment services. Safer supply programs must consider if, when, and how they will engage with youth who are at high risk. Youth are more likely to engage in services that are tailored specifically for youth. Safer supply programs that work with youth should refer to youth-focused ancillary services. Provincial benefit plans may require a Collaborative Practice Agreement and an exemption in order to provide coverage for hydromorphone for youth.

There are concerns that youth may be misled by the term ‘safer supply’. Studies have suggested that youth perceive pharmaceutical drugs to be safe, and may underestimate the potential for harm inherent in opioid use<sup>6 7</sup>. As such, safer supply education targeted at youth is important component to safer supply interventions.

## First Nations and Indigenous communities

In the work of our task team, we spoke to people who work with First Nations and Indigenous communities. We heard that harm reduction approaches to substance use are not always well understood or well received in First Nations and Indigenous communities. With the support of elders and chiefs, it is possible to set up safer supply programs based on the success of community-based OAT programs. First Nations communities need appropriate resources and capacity. In many areas, there are very few addiction treatment or harm reduction services. As such, it is important to provide information and education about harm reduction and safer supply, and to approach providing safer supply projects in a culturally aware manner. Indigenous harm reduction principles and practices integrate cultural knowledge and values into the strategies and services of harm reduction. Models for First Nations and Indigenous communities need to address issues such as intergenerational trauma, poverty, and resource scarcity. Models need to take into consideration that many people may already be caught up in systems that impose abstinence and heavily surveil them (e.g., child welfare, probation). Protocols for safer supply should also include spiritual protocols, created by elders.

Safer supply interventions should be designed, delivered, and evaluated by or in partnership with members of the First Nations or Indigenous community being served. Non-Indigenous prescribers, health practitioners, or program staff must receive training in cultural safety and cultural humility. There are several learning opportunities available that are listed below.

### **Resources:**

- **Honouring our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada.** Thunderbird Partnership Foundation. Available at: <https://thunderbirdpf.org/honouring-our-strengths-full-version/>

- **The Native Wellness Assessment (NWA)** instrument measures wellness from a cultural and strength-based approach. It demonstrates the effectiveness of First Nations culture as an intervention for addressing substance use and mental health issues. Available at: <https://thunderbirdpf.org/about-tpf/scope-of-work/native-wellness-assessment/#bookshelf>
- **Indigenous Harm Reduction Principles and Practices: Fact Sheet.** First Nations Health Authority. Available at: <http://www.fnha.ca/wellnessContent/Wellness/FNHA-Indigenous-Harm-Reduction-Principles-and-Practices-Fact-Sheet.pdf>

***Cultural safety learning opportunities*** (recommendations provided by CRISM 2019):

- National Indigenous Cultural Safety Learning Series: <http://www.icscollaborative.com/>
- Ontario Indigenous Cultural Safety Program (Southwest Ontario Aboriginal Health Access Centre) <http://soahac.on.ca/ics-training/>
- Nunavut Program's Cultural Competency Modules: <https://www.cheo.on.ca/en/Nunavut-Program-Modules>
- Saskatoon Health Region Cultural Competency and Cultural Safety Tool Kit: [https://www.saskatoonhealthregion.ca/locations\\_services/Services/fnmh/Pages/Cultural-Competency-Safety-Resource-Centre.aspx](https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/Pages/Cultural-Competency-Safety-Resource-Centre.aspx)
- Manitoba Indigenous Cultural Safety Training: <http://www.wrha.mb.ca/aboriginalhealth/education/MICST.php>
- College and Association of Registered Nurses of Alberta's Cultural Safety Webinar: <https://www.nurses.ab.ca/practice-and-learning/learning-opportunities/webinars/webinar/cultural-safety>
- San'yas Indigenous Cultural Safety Training (BC Provincial Health Services Authority Aboriginal Health Program): <http://www.sanyas.ca/>
- Cultural Safety and Cultural Humility Webinar Series (First Nations Health Authority and BC Patient Safety and Quality Council): <http://www.fnha.ca/wellness/cultural-humility/webinars>

For information about service delivery models that may be adapted for First Nations and Indigenous communities in remote or rural areas, please see **Section 3.1.3**.

## LGBT2Q+

The term LGBT2Q+ refers to lesbian, gay, bisexual, trans, Two-Spirited, queer and other gender and sexually diverse individuals. LGBT2Q+ individuals frequently face barriers to accessing services, including stigma, discrimination, and harassment. Safer supply programs need to be safe, non-judgmental spaces that welcome LGBT2Q+ individuals and that demonstrate sensitivity and awareness. Strategies<sup>8</sup> include:

- The use of inclusive language by all staff and in all documentation and materials;
- Providing trans and gender-non-conforming brochures and materials;
- Asking about gender identity on intake forms;
- Providing gender-neutral bathrooms;
- Ensuring all staff are appropriately trained; and
- Ensuring that referrals to community services are inclusive and appropriate.

<sup>1</sup> Galea S. The Social Epidemiology of Substance Use. (2004). *Epidemiologic Reviews*, 26(1):36–52.

<sup>2</sup> Galea S, Vlahov D. (2002). Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public health reports* (Washington, DC : 1974). Sage Publications, 117(Suppl 1), S135–45.

<sup>3</sup> Canadian Research Initiative in Substance Misuse (CRISM). [Not yet published]. *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Clinical Guideline*. Retrieved from: <https://crism.ca/projects/ioat-guideline/>

<sup>4</sup> Oviedo-Joekes E, Guh D, Brissette S, et al. (2010). Effectiveness of diacetylmorphine versus methadone for the treatment of opioid dependence in women. *Drug and Alcohol Dependence*, 111(1-2), 50-57. doi 10.1016/j.drugalcdep.2010.03.016

<sup>5</sup> Boyd J, Collins AB, Mayer S, Maher L, Kerr T, McNeil R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction*, 113(12), 2261-2270. doi: 10.1111/add.14417

<sup>6</sup> Kerr T, Oleson M, Tyndall MW, Montaner J, Wood E. (2005). A description of a peer-run supervised injection site for injection drug users. *Journal of Urban Health*, 82(2), 267–75.

<sup>7</sup> Daniulailtyte R, Falck R, Carlson RG. (2012). “I’m not afraid of those ones just ‘cause they’ve been prescribed”: perception of risk among illicit users of pharmaceutical opioids. *International Journal of Drug Policy*, 23(5), 374-84.

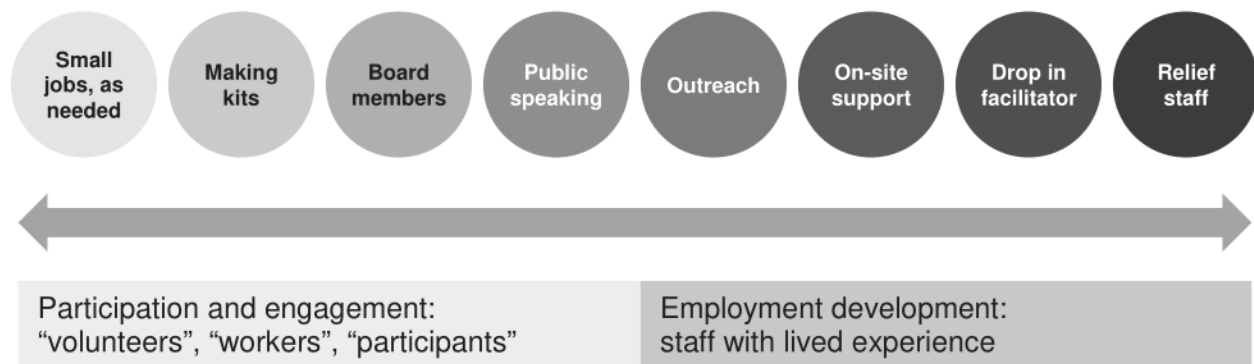
<sup>8</sup> Canadian Research Initiative in Substance Misuse (CRISM). [Not yet published]. *National Injectable Opioid Agonist Treatment for Opioid Use Disorder Operational Guidance*. Retrieved from: <https://crism.ca/projects/ioat-guideline/>

## 4.5 Engaging and employing people who use drugs

Engaging people with lived experience of drug use in the design, delivery, and evaluation of programs and services is a core principle of harm reduction and a best practice for harm reduction programs<sup>1</sup>. Studies show the effectiveness of services delivered by people who use drugs to reach a wide range of people, and to promote safer drug use behaviour<sup>26 23</sup>. For those engaged in program design, delivery, and evaluation, studies demonstrate positive outcomes such as improved health, stabilized substance use, and reduced social isolation<sup>26 27 4</sup>. Providing engagement and employment opportunities to people who use drugs is one way that organizations providing services to this community can directly address their social determinants of health (e.g., social inclusion, income, employment).

There are multiple ways to include people who use drugs across all stages of the design, implementation, and evaluation of safer supply programs, ranging from very low-threshold ‘odd jobs’, to consultation, to formal casual or permanent employment. This is depicted on a continuum of peer work, shown in Figure 4.5<sup>32</sup>:

**Figure 4-1** – A continuum of engaging and employing people who use drugs



On this continuum, the *participation and engagement model* is one that is designed with empowerment ideals, has inclusive goals (i.e., open to anyone regardless of their level of stability, skills, or experience), a focus on relationship-building, and a commitment to work with people who use drugs in a low-threshold, non-coercive manner. Only basic training is required to complete supervised instrumental tasks such as assembling safer injection kits, or welcoming people to the program. Opportunities to participate in these ways are believed to help participants increase control over their health by providing a supportive environment, health education, and harm reduction supplies, and building community capacity to share information within their social networks. Participants should be provided compensation for their work, such as through honoraria.

The *participation and engagement model* provides a critical entry point to employment by providing opportunities for people who use drugs to develop skills and self-confidence and, perhaps, to spark their interest and ability to embark on more advanced employment training and work opportunities, including formal employment in casual, part-time, or full-time positions. Employment development models provide a balance between low-threshold and more structured employment, providing a supportive environment that recognizes the challenges to maintaining employment that are faced by people who use drugs, including those arising from criminalization, homelessness or precarious housing, and mental and physical health challenges.

There are an increasing number of examples of programs across Canada that are formally employing people who use drugs as staff members, many of whom worked their way up from volunteer positions. Many funders are now requiring that people who use drugs are involved in services geared for them. However, it is important that engaging and employing people who use drugs is well thought out by agencies, and that they do the organizational work to ensure that employees with lived experience are engaged meaningfully and equitably. This includes funders and/or organizations clearly defining terms such as ‘engagement’, ‘involvement’, ‘representation’, and ‘consultation’ (amongst others), using criteria to make sure that these terms are used to provide meaningful and equitable opportunities for people who use drugs.

There are a number of resources available to assist with supporting the engagement and employment of people who use drugs. These are listed at the end of this section. Here, some considerations are offered to support the safety, equity, equality, and meaningful engagement and employment of people who use drugs in the design, delivery, and evaluation of safer supply projects.

### **Consultation and program design**

Consulting with people who use drugs will help identify ways of making programs accessible, welcoming, and effective, and in ensuring that the vision and mission of the project reflects the needs and wants of people who use drugs in the community. Efforts to be made to consult with people in a variety of ways, including multiple consultation meetings, interviews, and surveys. Time spent providing consultation should be recognized as labour, and compensated with an honorarium sufficient to also cover expenses incurred (e.g., travel costs).

In addition to consultations, people who use drugs should have a presence on a program advisory committee, alongside other stakeholders, such as physicians, nurses, social workers, and harm reduction workers. Again, this participation should be recognized as labour, and compensated accordingly. Advisory committees should have a terms of reference that ensures that all members are to be treated with respect, dignity, and as equals.

Please see **Section 6: Community of Practice** for more information on how organizations of people who use drugs may be engaged to support safer supply program development.

### Program delivery

People who use drugs have a valuable role in the delivery of programs. Employing people who use drugs to deliver services provides benefits to the clients, and the employed people. Clients report feeling more comfortable and having more confidence in services where people who use drugs are employed. And people who use drugs often face considerable barriers to employment and income. Low threshold employment provides opportunities to gain some skills and earn some extra income, while also enhancing self-esteem, a sense of inclusion and purpose. For some, this leads to increased stability in other areas of their lives (housing, substance use).

There are different titles for staff roles held by people who use drugs: some that identify them as people with lived experience, e.g., ‘peer workers’, and other roles are named according to the task or program but are reserved for people with lived experience, e.g., outreach worker, harm reduction worker, intake worker. Safer supply programs require a number of professional staff, including nurses and a prescriber, but there are many roles that people without such training but with lived experience could hold. For example, welcoming clients, providing orientation to the program and services, delivering harm reduction and overdose prevention education, maintaining stocks of drug use equipment and supplies, appointment accompaniment, providing referrals, facilitating support groups, and more.

Organizations who employ people who use drugs, especially in low threshold work opportunities, must ensure that organizational policies do not create conflicts or barriers, and do promote equity and equality in the workplace. Workplaces must ensure that people are fairly compensated, and that they are included in organizational opportunities and functions (e.g., training, meetings, support). People who use drugs and are in low threshold employment should be well trained and provided with regular supervisory support. For more information on providing positive low threshold employment opportunities for people with lived experience, please see the resources below.

### Evaluation

People who use drugs should be involved in the design, data collection, analysis, and dissemination of evaluation findings. The involvement of people who use drugs and have lived/living experience should be recognized as labour and be fairly compensated. Community-based research and participatory action research are two approaches that prioritize the involvement of community members, in this case, people who use drugs. These approaches should inform evaluations and other research on safer supply programs.

### Resources for engaging and employing people who use drugs:

Balian, R. and White, C. (2010). *Harm Reduction at Work: A guide for organizations employing people who use drugs*. Open Society Foundations. Retrieved from: <https://www.opensocietyfoundations.org/sites/default/files/work-harmreduction-20110314.pdf>



Becu, A. and Allan, L. (2017). *Peer Payment Standards for Short-Term Engagement*. Vancouver, BC: BC Centre for Disease Control. Retrieved from: [http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer\\_payment-guide\\_2018.pdf](http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer_payment-guide_2018.pdf)

Canadian HIV/AIDS Legal Network. (2005). *"Nothing About Us Without Us"—Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative*. Toronto, ON. Retrieved from: <http://www.aidslaw.ca/site/wpcontent/uploads/2013/04/Greater+Involvement+-+Bklt+-+Drug+Policy+-+ENG.pdf>.

Greer, A.M., Amlani, A.A., Buxton, J.A. & the PEEP team. (2017). *Peer Engagement Best Practices: A Guide for Health Authorities and other providers*. Vancouver, BC: BC Centre for Disease Control. Retrieved from: <http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guideli>

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<sup>2</sup> Mason, K. (2006). *Best practices in peer harm reduction projects*, Street Health, Toronto. Retrieved from: <http://www.streethealth.ca/downloads/best-practices-in-harm-reduction-peer-projects-spring-2007.pdf>.

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# Section 5

## Approaches to Evaluation

## 5. Approaches to Evaluation

Evaluation is a critical component of piloting safer supply projects. There are a number of approaches that may be used for evaluation. Here, considerations are offered for looking at evaluating safer supply evaluations in multiple sites, as well as individual sites.

### Key considerations:

- Research activities for safer supply programs should be looked at as **implementation science**, instead of as clinical trials. Clinical and evaluation studies can be separated, thereby streamlining the review processes. There is a sufficient body of evidence supporting the use of iOAT for opioid use disorder; however, evaluations of the effectiveness of safer supply programming in reducing illegal drug use and harms are still in the early stages, due to the recent emergence of these services.
- The establishment of an **expert peer-review committee** to review research protocols would streamline review processes for both funding and research ethics reviews. This committee could be a branch of a safer supply community of practice.
- **Ethical evaluation tools** are available to assist organizations working through the considerations involved with establishing safer supply research pilot projects and evaluations. These include:

British Columbia Ministry of Health. (2017). *Responding to British Columbia's Overdose Public Health Emergency – An Ethics Framework*

Retrieved from: <https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/overdose-public-health-emergency-ethics-framework-march-2017.pdf>

Public Health Agency of Canada. (2017). *Framework for Ethical Deliberation and Decision-Making in Public Health: a Tool for Public Health Practitioners, Policy-Makers, and Decision-Makers*.

Retrieved from:

[http://publications.gc.ca/collections/collection\\_2017/aspc-phac/HP5-119-2017-eng.pdf](http://publications.gc.ca/collections/collection_2017/aspc-phac/HP5-119-2017-eng.pdf)

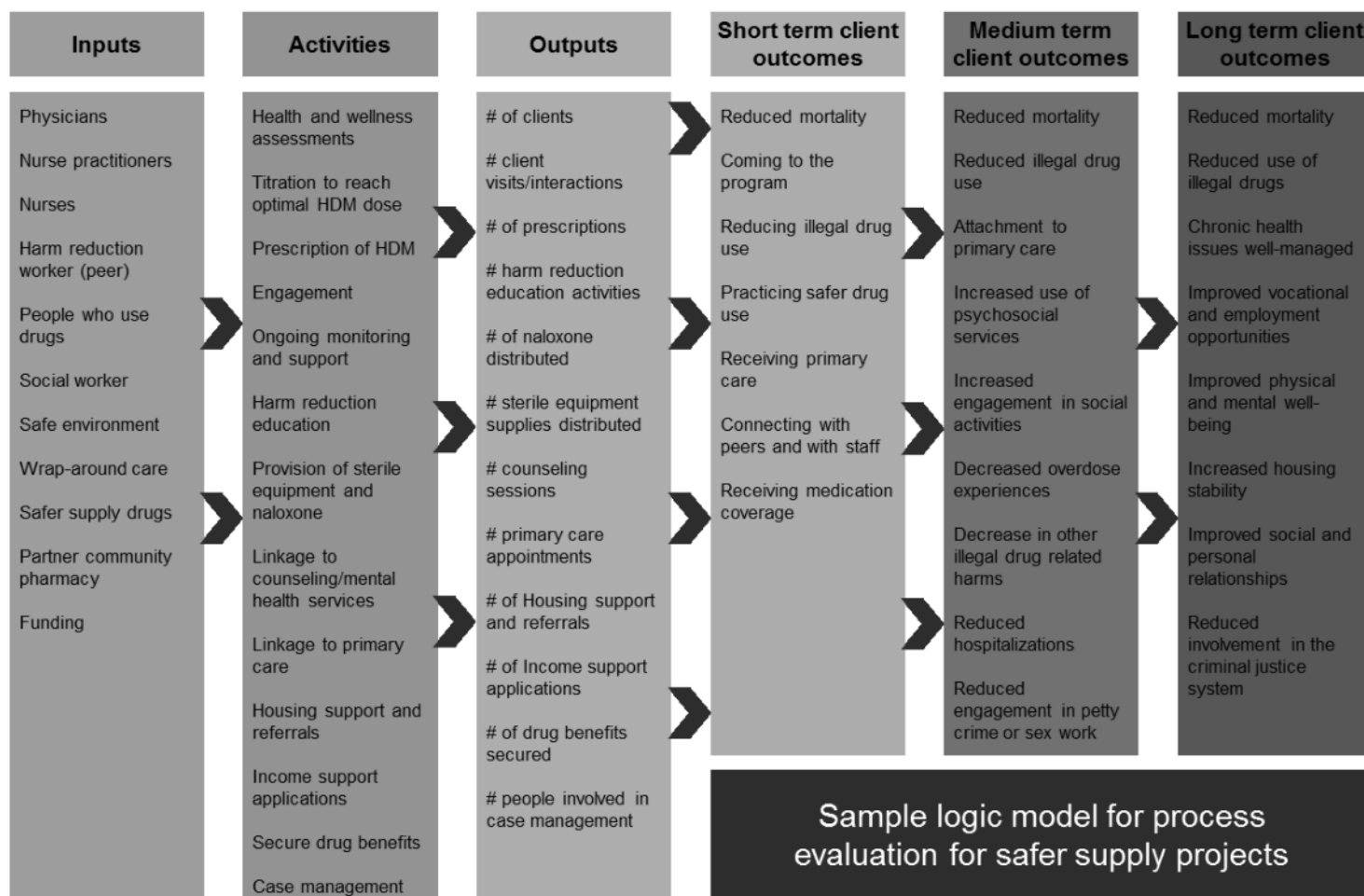
- **Research and evaluation of new models** of safer supply programs, i.e., flexible models, are needed to determine the effectiveness of these approaches to safer supply, as well as to understand any potential risks or harms. There currently exists a growing evidence base on iOAT; additionally, there are already current and upcoming funded research pilot projects of lower-threshold iOAT and TiOAT community programs (e.g., PHS Moslon OPS, Ottawa Inner City Health MOP, BCCDC Oral Hydromorphone feasibility study).

- There are arguments that support a **coordinated Canada-wide, multi-site evaluation** of safer supply projects that uses a single protocol and with data collected by local researchers (including peer researchers). This would provide a wealth of data using a higher sample, permitting greater confidence in results. However, such a study would be costly and take considerable time to get off the ground. It may also be difficult to tease out the safer supply interventions, if they are embedded in treatment interventions.
- Others argue that evaluations should be **smaller scale and locally-driven**, reflecting the needs and goals of the local community, and conducted by members of the community (e.g., local researchers, selected by the organization, using participatory and community-based research approaches, including employing people with lived experience).
- Where possible, **operations and evaluation should be kept separate**. This may be difficult in the context of resource restraints.
- **Innovative approaches** to program evaluations may be developed to combine both small-scale process evaluations, with larger scale multi-site studies. Approaches may include:
  - All SUAP-funded projects being required to collect specific types of data, using standardized definitions of outcomes of interest and ways of measuring;
  - Using a low-cost open data model to allow researchers to access data to use, with the consent of the communities involved (see below);
  - Having a national evaluation committee with local representatives from safer supply projects oversee the development of a standardized protocol that includes outcomes of interest, data collection tools, and a data dictionary to ensure common understanding and interpretation
- Both a multisite study and local research and evaluations need to draw on **participatory and community-based research approaches**, in which community members (people who use drugs and safer supply services) are involved in the design of the evaluation, data collection, analysis, and dissemination.
- Research and evaluation of safer supply pilot projects in rural and remote areas and/or involving First Nations and Indigenous people should employ community-based research and evaluation methods that include **community capacity building**. For example, if relying on researchers from outside of the community, community research and evaluation capacity should be developed, and analysis should be undertaken in partnership with community members.
- **Primary outcomes of interest:** The primary outcomes of interest must be connected to the goals of safer supply: **to reduce illegal drug use and to reduce adverse events related to illegal drug use** (including death, overdoses, and other health harms, as well as criminalization, involvement in petty crime, and sex work). Other outcomes of interest

may include: *attachment to primary care, connecting with additional health and social services, engagement in programming, reduced hospitalizations, reduced interactions with the criminal justice system.*

- **Process evaluations** (also known as formative or implementation evaluations) are useful for assessing project operations and determining if the project is operating as intended. This is critical for safer supply projects, where evidence is needed to help ensure that the benefits outweigh the risks of harm or actual harms. This is particularly the case for prescribing practices that extrapolate from the evidence and are not well supported with clinical guidelines. Process evaluations can identify where and how project components may need to be adjusted to improve service delivery.
- Process evaluation **findings can be shared through communities of practice**, and contribute to the development of best practices and a framework for safer supply interventions.

The following logic model provides an example of how a process evaluation may work:



### Open data models

Open data models refers to mechanisms that make data that is collected for monitoring or evaluation as accessible as possible to people who want to do evaluations. For example, programs are often required to report their data routinely to their funders as a condition of funding. For safer supply programs embedded in supervised consumption sites, supportive housing, or community health centres, this data reporting is already in place. Such organizations that receive funding from the Substance Use and Addictions Program (SUAP) may have reporting requirements for outcomes of interest. By establishing an open data model, researchers could have access to that data, without having to file a data request or even a freedom of information request to access those data. One step beyond this would be to have de-identified individual-level data available, such as through a registry in which everyone who enrolls in a Health Canada (ideally) or provincial-funded program to access safer supply would be entered into an registry that tracks a core set of data.

Open data models are an increasingly common practice in the United States, and are beginning to be employed in Canada. For examples of open data sharing, see:

- National Institute on Drug Abuse funded studies: <https://datashare.nida.nih.gov>
- National Survey on Drug Use and Health data: <https://www.samhsa.gov/data/> and <https://pdas.samhsa.gov>

### Data dictionaries

It's important to note that open data sharing might not be accepted in some communities, including Indigenous and First Nations communities. Communities may be averse to open data models, and prefer to have control over where their data goes and how it is used. It is important to **explore alternative approaches to promoting comparability** without the sharing of specific data, for example using data dictionaries to define outcomes.

# Section 6

## Engaging with a community of practice

## 6. Engaging with a Community of Practice

Responding to the current overdose crisis requires multiple bold, innovative approaches to reduce illicit drug use as well as strengthening existing harm reduction and treatment services. One way of encouraging innovation and enhancing the capacity of health care and social care providers is to create a community of practice. Across Canada, many health care and social care providers, drug policy organizations, and organizations of people who use drugs are engaged in conversations about safer supply more broadly, and safer supply programs specifically. Some of these are informal email groups, while others are more formalized regional groups. The conversations are diverse, and reflect the complexity of the issue, and the different ways that safer supply is conceptualized and operationalized.

A community of practice is particularly important for health care professionals who are extrapolating from the evidence and trying new approaches, and practicing without the safety net of established professional guidelines and bodies of evidence. Consulting with peers (including clinical, social, PWLE) provides a way of working through ethical issues and professional standards of care, as well as gaining insights into practices, successes, and failures.

A Safer Supply community of practice should include participants from multiple disciplines, including health practitioners, harm reduction and addictions workers, and community members (i.e., people who use safer supply programs, people with lived/living experience).

Sub-groups could be established from a community of practice, such as:

- An expert peer-review committee to review research protocols and funding applications
- An evaluation committee to develop evaluation protocols (including data dictionaries) and to disseminate findings
- A emerging practices committee to collectively develop safer supply practice guidelines

### **Building capacity of organizations of people who use drugs and harm reduction networks**

If sufficiently resourced, new and existing organizations of people who use drugs and harm reduction networks may be deployed to provide education and support about safer supply. Additionally, these organizations and networks could assist organizations to develop capacity to meaningfully and effectively engage and employ people with lived experience. This may include a cross-organizational network of PWLE who work with agencies to develop equitable workplace policies. The establishment of a *Safer Supply Access Council*, led by people who use drugs, service providers, and practitioners, could provide support to local safer supply efforts, as well as provide education and information to service providers and regulatory bodies.



# Section 7

## Additional Resources

## 7. Additional Resources

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**MINISTRY OF MENTAL HEALTH AND ADDICTIONS  
DECISION BRIEFING NOTE**

**Cliff #1138928**

**PREPARED FOR:** Neilane Mayhew, Deputy Minister and Stephen Brown, Deputy Minister - **FOR DECISION**

**TITLE:** Expansion of the Tablet injectable Opioid Agonist Treatment Pilot Program

**PURPOSE:** To obtain a decision regarding the possible expansion of the Tablet injectable Opioid Agonist Treatment (TiOAT) pilot project to three sites serving a total of 250 patients using Dilaudid® as a low-barrier treatment option for opioid use disorder (OUD) and as a safer supply option.

**BACKGROUND:**

British Columbians continue to experience unprecedented rates of overdose-related harm due to an unregulated drug supply that is highly toxic and unpredictable. At least 1,514 people died from a suspected overdose in 2018.<sup>i</sup> The rate of fentanyl detection in overdose deaths has increased from 4% in 2012 to 87% in 2018.<sup>ii</sup> Available data show that overdose emergency disproportionately impacts status First Nations, particularly those living in urban centres.<sup>iii</sup>

Providing people most at risk of overdose with access to a regulated supply of prescription opioids has the potential to save lives in the context of an overdose emergency. The BC Overdose Action Exchanges 2016, 2017, and 2018 reports<sup>iv</sup> and a Vancouver Police Department position paper in 2017<sup>v</sup> recommended increased access to a safer drug supply to reduce overdose-related harms associated with the unregulated drug supply.

In December 2017, the Ministry of Mental Health and Addictions established the Overdose Emergency Response Centre to oversee the implementation of a comprehensive package of essential services for overdose prevention. The package includes “supporting a diversity of community-level, low-barrier services tailored to population/community needs such as...a safer drug supply (e.g., hydromorphone in supervised settings).<sup>vi</sup>

In December 2018, a Safer Opioid Supply (SOS) Working Group was struck at the request of the Minister of Mental Health and Addictions to develop a safer supply strategy that identifies immediate actions to save lives of those at high risk of overdose death due to the toxicity of the unregulated drug supply.

In April 2019, the SOS Working Group released its final report, which included several recommendations for follow up and implementation including urgently implementing and evaluating emergency drug supply interventions. Specifically, the SOS Working Group recommended

s.13

s.13

#### Portland Hotel Society (PHS) TiOAT Pilot Project

In January 2019, in adherence with the OPHO principles, the PHS Community Services Society launched a pilot program at the Molson OPS in Vancouver using hydromorphone tablets as part of the iOAT continuum of care. This option is available for people who have not benefitted from traditional OAT and iOAT programs, who are at a very high risk of overdose and have experienced multiple overdose events. Most patients are also co-prescribed OAT and are supported to move along the continuum of care to meet their clinical needs, with a goal to eliminate illegal drug use and transition to oral treatment.

To enter the program, patients must meet with the physician for an evaluation and to receive a prescription. A second physician signs off on each TiOAT start. A 6-month prescription for 70, 8mg tablets per week of hydromorphone is provided. Patients can have 1-2 tablets up to 5 times a day PRN with a minimum of 1 hour between doses.

Patients can take the hydromorphone orally or crushed for injection (off label use) under medical supervision. To prevent diversion, tablets for oral consumption are crushed and put in applesauce and tablets for injection are crushed with a small amount of sterile water.

PharmaCare agreed to cover the cost of the generic oral hydromorphone tablets as part of a fixed-length pilot through a health authority-operated pharmacy, for a fixed number of patients, to provide exceptional support as part of the provincial overdose emergency response. Normally, medications for pilot projects are not billable to PharmaCare. Other operational costs have been funded through the Community Crisis Innovation Fund.

#### **DISCUSSION:**

The pilot has been successful in engaging and retaining patients, reaching full capacity by March 2, 2019, with a retention rate of 90%. Preliminary results from the pilot (n=60) demonstrate that since starting the program, no patients have had an overdose event, reported reduced drug use, increased engagement with primary care and OAT induction and maintenance. Preliminary findings indicate that this model is a cost-effective way of engaging a high-risk population in treatment, saving lives, and engaging patients in care. The BC Centre on Substance Use is also evaluating the pilot as part of the iOAT long cycle evaluation, including quantitative (n=15) and qualitative protocols (n=30).

There is support from the Minister of Mental Health and Addictions and endorsement from the Joint Steering Committee on BC's Overdose Response for expansion of the TiOAT pilot to save lives. Expansion plans include increasing patient capacity at the existing site (100 patients) and expanding to two additional sites: Powell Street Getaway (100 patients) and Kamloops (50 patients). The TiOAT pilot will be funded for a fixed period of time, after which a decision will be made to continue based on the evaluation results.

There are two barriers to expansion: access to brand-name Dilaudid® and use of a community pharmacy. TiOAT patients have expressed a strong preference for brand-name Dilaudid® as generic hydromorphone tablets do not dissolve as well and contain more chalk. Access to Dilaudid® would increase retention and reduce harms from injecting. Lower Mainland Pharmacy does not have the capacity to support additional pilot sites. Use of a community pharmacy would support the acquisition of Dilaudid® and address capacity limitations.

There are some concerns that the off-label use of hydromorphone may lead to negative health effects. In the context of the overdose emergency, there is a critical need to re-define 'risk' given high rates of overdose morbidity and mortality and to innovate rapidly and evaluate simultaneously. These concerns can be identified and monitored through a short-cycle research methodology, in addition to the existing long-cycle provincial iOAT study. Evaluation findings will inform the development of risk mitigation/quality improvement strategies.

#### **FINANCIAL IMPLICATIONS:**

s.13; s.17

#### **OPTIONS:**

s.13

s.13

**RECOMMENDED OPTION:** s.13

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Approved/Not Approved  
David Byres  
Associate Deputy Minister, Ministry of Health

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Date Signed

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Approved/Not Approved  
Neilane Mayhew  
Deputy Minister, Mental Health and Addictions

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Date Signed

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**Drafter:** Jennifer MacKenzie and Kendall Hammond, Overdose Emergency Response Centre

**Date:** July 5, 2019

**File Name with Path:**

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- <sup>iii</sup> First Nations Health Authority. (2019, May 27). *First Nations Opioid Overdose Deaths Rise in 2018*. Retrieved from: <http://www.fnha.ca/about/news-and-events/news/first-nations-opioid-overdose-deaths-rise-in-2018> (accessed July 4, 2019).
- <sup>iv</sup> Meeting reports from each BC Overdose Action Exchange are available at: <http://www.bccdc.ca/our-services/programs/overdose-response>.
- <sup>v</sup> Vancouver Police Department. (2017, May). *The Opioid Crisis: The Need for Treatment on Demand*. Retrieved from: <https://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf> (accessed July 4, 2019).
- <sup>vi</sup> Ministry of Mental Health and Addictions. (2017). *Overdose Emergency Response Centre – Terms of Reference*. Retrieved from: [https://www2.gov.bc.ca/assets/gov/overdose-awareness/terms\\_of\\_reference\\_nov\\_30\\_final.pdf](https://www2.gov.bc.ca/assets/gov/overdose-awareness/terms_of_reference_nov_30_final.pdf) (accessed July 4, 2019).



# TiOAT Preliminary Data (80 clients)

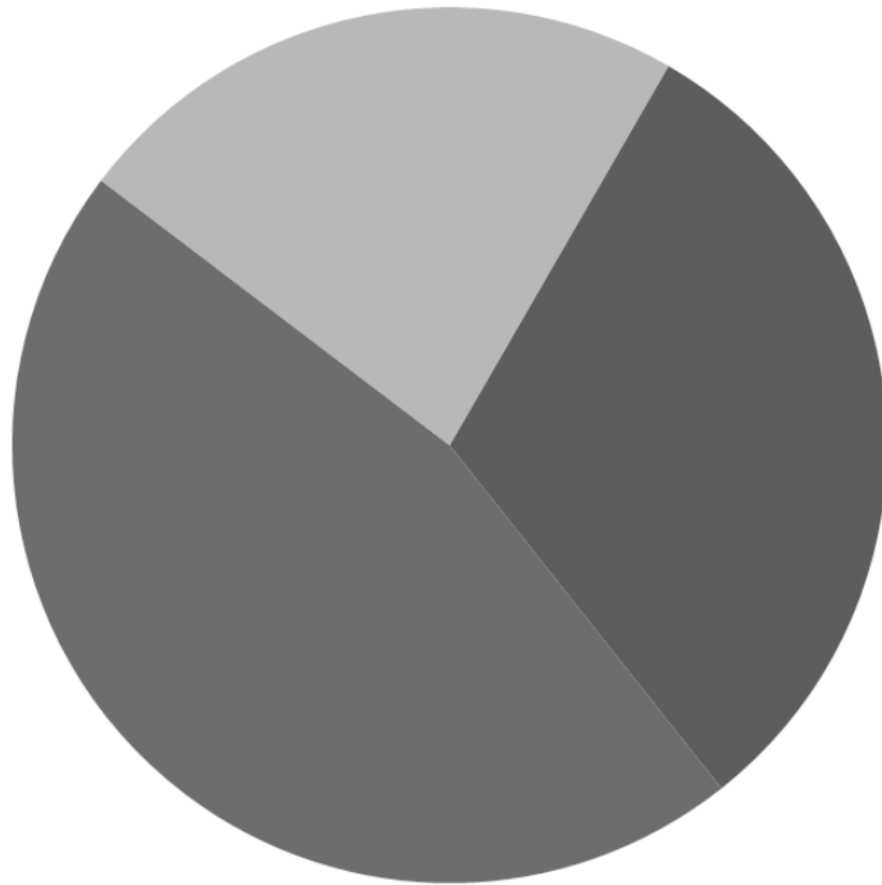
September 2019

# TiOAT Program

TiOAT is a program based on a model of “as needed” medication for treatment of opiate use disorder, an alternative to traditional iOAT

- No titration schedule necessary
- Target is the same = using medication to reduce harm ie. overdoses, criminal behaviour, HIV/HCV transmission

# Route of TiOAT



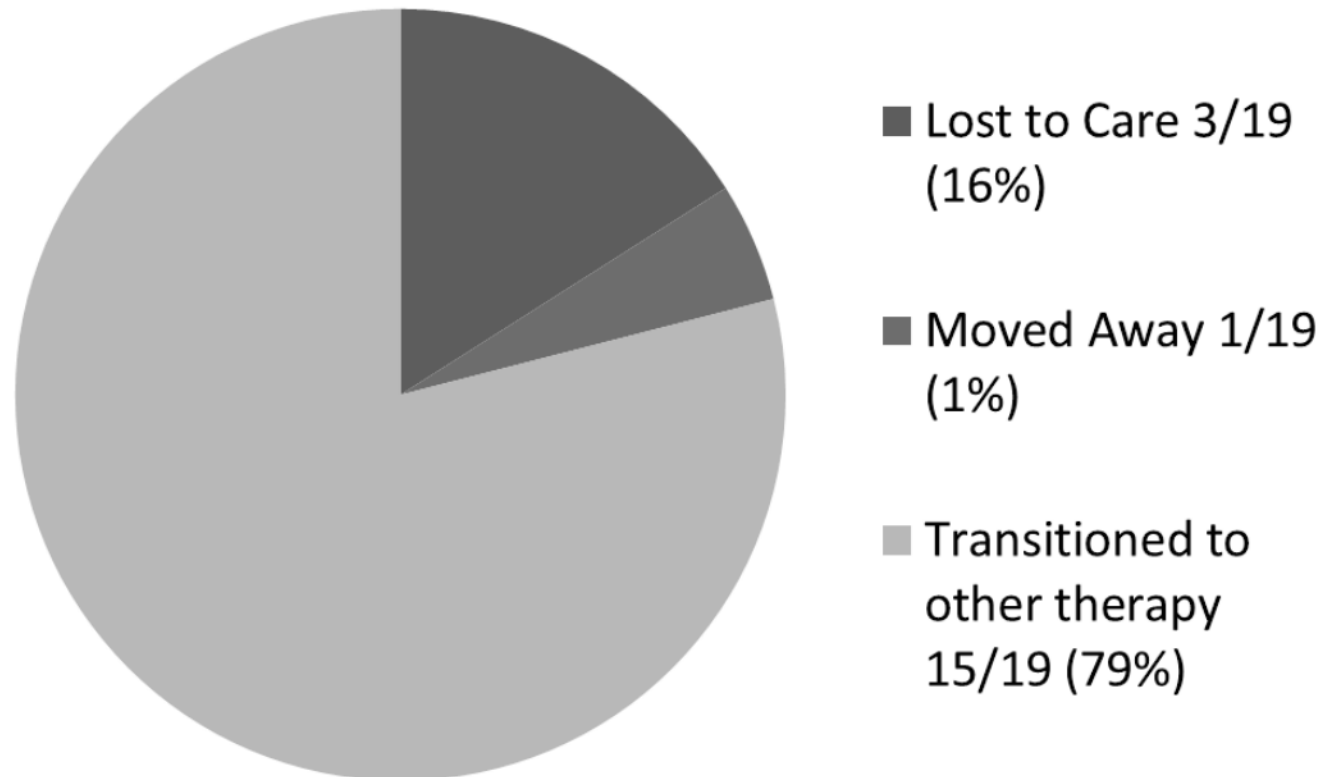
- Oral only 25/80 (31%)
- Injection only 37/80 (46%)
- Oral & Injection 18/80 (23%)

Note: 8/80 (10%) of clients switched to liquid iOAT when space became available

# Retention

- Proportion of clients retained on treatment? **61/80 (76%)**
- Of those still on **active treatment**, using Aug 31 as the cut-off date, average number of days: **145 days**
- Combined (active & non-active treatment, excluding the 3 cases noted above): Average **135 days**
- Combined (active & non-active treatment, including the 3 cases noted above): Average **133 days**
- Of those **not retained in treatment**, average number of days spent in the program: **96 days** (Note: 2 cases were excluded as only the month for end date was given but no exact date. If included, and using the middle of the month as the end date, the average number of days of retention is **92**).

## Discontinued Clients



Proportion of clients discharged from program: 19/80 (24%)  
79% transitioned to long-acting daily medication (traditional OAT)

# Successful Transition to Stabilized Treatment

Transitioned to oral OAT  
12 clients

Transitioned to iOAT  
2 clients

Transitioned to other treatment  
1 client

Average time clients spent in program before transitioning to OAT?

- For the 15 clients who transitioned, including 1 case where exact date is unknown, the average time spent in the program before transitioning: **96 days**
- For 15 clients, excluding the 1 case noted above, the average time clients spent in the program before transitioning: **99 days**

Many of the clients enrolled in the program where disengaged to the health system are now accessing primary care.

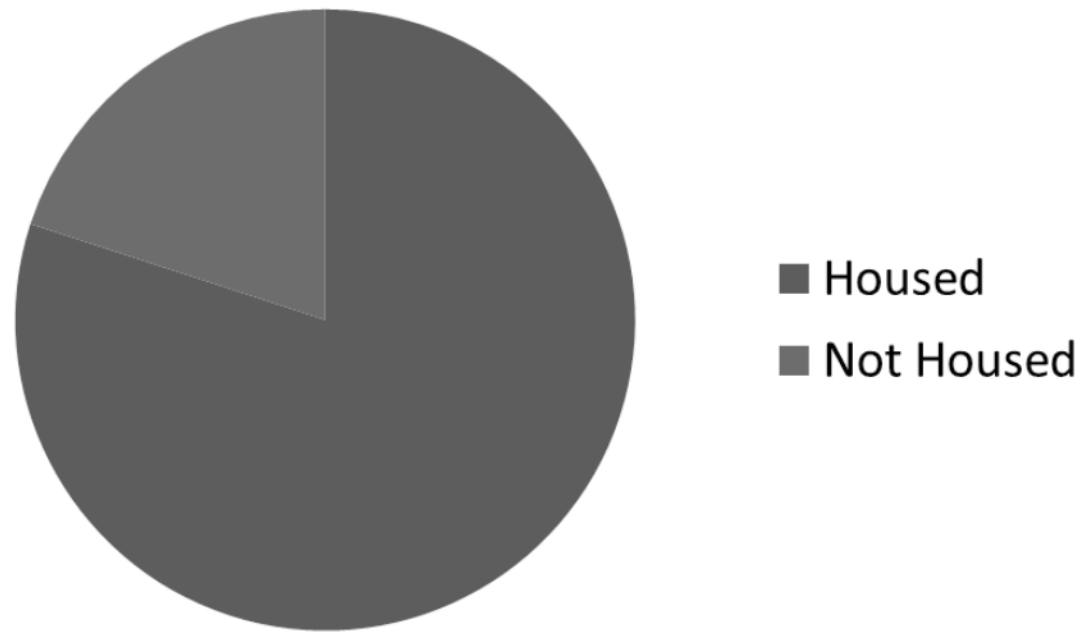
# OAT within TiOAT

Clients on OAT & TiOAT: 73/80 (91%)

Clients on TiOAT only (declined OAT): 7/80 (9%)

91% of client engaged in OAT while accessing TiOAT

## Housing



### Additional notes:

#### **Housed: 80% (64/80)**

- active & housed: 49 (80% of active clients; 77% of housed clients)
- discontinued & housed: 15 (79% of discontinued clients; 23% of housed clients)

#### **Not Housed: 20% (16/80)**

- active & not housed: 12 (20% of active clients; 75% of not housed clients)
- Discontinued & not housed: 4 (21% of discontinued clients; 25% not housed clients)



# Injection Complication

History of Cellulitis/abscesses:	7.5% (6/80)
Hospitalization:	none

Opportunity to support high risk population of injection comorbidity in community and prevent costly ED visits and lengthy hospitalization

## Thomson, Krystal MMHA:EX

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**From:** Newhook, Kelly TAC:EX  
**Sent:** September 21, 2019 11:42 AM  
**To:** Darcy, Judy MMHA:EX  
**Subject:** FW: approved KMs  
**Attachments:** Proposed KM's on SS - September 2019\_final.docx

Here are the approved KM's as per our conversation late yesterday. Sorry for the delay but my computer kept jamming up. Finally working again!

Kelly

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**From:** Lindsay-Baugh, Anna MMHA:EX  
**Sent:** Friday, September 20, 2019 4:24 PM  
**To:** Newhook, Kelly TAC:EX <Kelly.Newhook@gov.bc.ca>; Berndt, Eric GCPE:EX <Eric.Berndt@gov.bc.ca>  
**Subject:** approved KMs

See attached

--

**Anna Lindsay-Baugh**  
Ministerial Assistant to the  
Honourable Judy Darcy  
Minister of Mental Health and Addictions  
Room 346 Parliament Buildings  
C: 778-677-4091 | [anna.lindsaybaugh@gov.bc.ca](mailto:anna.lindsaybaugh@gov.bc.ca)

## **Safe Supply – Main Message**

s.13

### **Background**

- In July 2019 the Federal Health Minister came to British Columbia to announce funding for pilot projects that include those that invest in safe supply.
- In September 2019, the Federation of Canadian Municipalities passed a resolution that specifically speaks to expanding safe supply measures.

## Thomson, Krystal MMHA:EX

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**From:** Newhook, Kelly TAC:EX  
**Sent:** September 19, 2019 4:36 PM  
**To:** Darcy, Judy MMHA:EX  
**Cc:** Lindsay-Baugh, Anna MMHA:EX  
**Subject:** FW: Statement

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**From:** Monckton, Neil <Neil.Monckton@vancouver.ca>  
**Sent:** Thursday, September 19, 2019 10:38 AM  
**To:** Newhook, Kelly TAC:EX <Kelly.Newhook@gov.bc.ca>  
**Cc:** Reid, Lauren <Lauren.Reid@vancouver.ca>  
**Subject:** Statement

This is either the final or near final but nothing changed in the paragraph on safe supply.

Today, I was extremely pleased to welcome Prime Minister Justin Trudeau to Vancouver City Hall. We spoke about deepening our partnership and working together to tackle the housing crisis, the overdose emergency, and congestion along one of Canada's busiest transit corridors.

On housing, I first thanked the Prime Minister for his government's unprecedented \$184-million investment in 1,100 social housing units announced earlier this August. I also expressed how heartened I am by Housing Minister Duclos' commitment to provide further funding for more modular housing and to repair and renew thousands of non-profit and co-op housing homes in our city. This is welcome news and I urged the Prime Minister to help accelerate action on these commitments so that we can turn the corner on the housing crisis.

I also expressed our deep gratitude for recent federal investments that have helped reduce the number of deaths due to overdose and for his commitment to advancing the safe-supply approach to saving lives. In addition, I requested the Prime Minister's assistance with securing Health Canada exemptions to allow health professionals to establish Vancouver's and Canada's first non-profit organization empowered to distribute a clean-drug substitute to people at risk of overdose.

Finally, I thanked the Prime Minister for funding the Millenium Line extension along Broadway to Arbutus Street. I expressed hope from across the Metro Vancouver region to extend the Broadway line to UBC bringing much-needed relief to commuters and reducing polluting emissions.

Working together, city council and the federal government have produced significant improvements for the lives of Vancouverites. By deepening our partnership, we can accomplish even more and build a city that works for everyone.

Sent from my iPhone