

RESPONDING TO THE OPIOID CRISIS: LEADING PRACTICES, CHALLENGES, AND OPPORTUNITIES

A Summary of the Ministerial
Roundtable on Opioids

June 12, 2017

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INTRODUCTION

Canada's opioid crisis continues to have devastating impacts on the health and well-being of Canadians, as evidenced by the large and growing number of hospitalizations and deaths attributable to opioid abuse. Tackling this public health emergency will require commitment from all affected parties from the Provincial/Territorial and Federal governments to front-line practitioners and first responders.

HealthCareCAN – the national voice of Canada's hospitals and healthcare organizations – is committed to doing everything it can to contribute to the collaborative response to one of the biggest public health threats facing Canada. HealthCareCAN members play a unique role in addressing this crisis; they know first-hand the importance of taking action and working collaboratively to reduce the harm associated with opioid addiction.

This document contains input from over 20 HealthCareCAN members and partners on critical aspects of a national response to the opioid crisis, including:

- Leading practices in harm reduction, prevention and surveillance, and treatment with opportunity for national scale and spread,
- Challenges unique to the hospital and health region sector, and
- Commitments and/or actions that HealthCareCAN members and partners could take to help mitigate the opioid crisis.

This document also contains key insights emerging from a June 12, 2017 invitational roundtable of HealthCareCAN members and other selected stakeholders with the Hon. Jane Philpott, Minister of Health. The roundtable was attended by more than thirty health leaders from across the country.

Co-chaired by Dr. Victoria Lee (Fraser Health Authority) and Mr. Bill Tholl (HealthCareCAN), the roundtable took a national perspective and focused on the critical role HealthCareCAN members will play in addressing the crisis. The discussion specifically revolved around the practical and concrete solutions HealthCareCAN members and partners have developed in the early days of the crisis, with the goal of facilitating their national scale and spread. The discussion also addressed the opioid crisis in terms of its intersection with the needs of vulnerable populations, including the unique needs of Canada's Indigenous peoples, and the specific challenges facing paediatric and rural populations.

It is important to recognize that no single intervention will provide a 'magic bullet' solution to the challenges we face. But it is hoped that the leading practices, challenges, and opportunities highlighted in this document will provide insight into the kind of progress that is possible, and how it can be achieved.

SECTION 1: LEADING PRACTICES

Leading practices provided by HealthCareCAN members have been divided into three categories: (1) harm reduction; (2) prevention and surveillance; and, (3) treatment.

1.1 Harm Reduction

At the roundtable, participants discussed the myriad of harm reduction activities being undertaken across the country. As participants noted, harm reduction responses have been prioritized in the Canadian response to the crisis. The focus on harm reduction reflects the acute nature of the crisis and the need for immediate solutions. A selection of harm reduction programs from Canadian healthcare organizations is presented below.

Participants stressed that conventional harm reduction techniques will not adequately address this crisis, given its scale and momentum. It was felt that the standard harm reduction toolbox (i.e. needle exchange programs and supervised safe consumption sites), while effective, should be paired with interventions further upstream. A robust response should address homelessness, mental illness, and traumas that so often precede opioid abuse disorders. Stigma against persons suffering from opioid use disorders is also a significant unaddressed element of the crisis.

Overdose prevention

- **Vancouver Coastal Health (VCH)** operates two supervised injection sites and has applied to establish two new sites. A provincial ministerial order has allowed VCH to establish 5 overdose Prevention Sites greatly increasing access to supervised injection services within the region. Taken together, these sites now see more visits than Insite and are successful in reversing a significant number of community overdoses.
- **The First Nations Health Authority** is working with the BC Centre for Disease Control to include access to Naloxone training and kits for First Nations communities as a component of the provincial response to the overdose crisis. The FNHA Indigenous wellness team has also created and delivered a variety of harm reduction sessions that draws from the traditional knowledge of First Nations in BC.
- **Interior Health's** mobile overdose prevention unit is a motor home fully equipped to assist intravenous drug users in case they overdose. Services provided include: overdose prevention and response, access to naloxone kits and other harm reduction supplies, access to primary care (wound, foot and burn care services), outreach to the surrounding area, and counselling and referral to treatment and other medical services.
- **The Healthy Sexuality and Harm Reduction program at Winnipeg Regional Health Authority** is piloting a door lock that is timed for 10 minutes before an external light goes on to signal staff to knock on the door. A number of other Winnipeg sites are installing this technology (Main Street Project, Aboriginal Health and Wellness). This is a novel and inexpensive intervention that was shared by Fraser Health and works well in places where supervised consumption services are not indicated, available or feasible. This way if a person overdoses on site he/she will be found early enough to have their overdose reversed.
- **Hamilton Health Sciences** will be rolling out a program on June 26, 2017 to provide naloxone rescue kits in all HHS Emergency Departments. A comprehensive training program for all Emergency Department staff has been undertaken. Educational materials have been developed for staff and patients. Patient instructions and educational materials include:

- Centre for Addiction and Mental Health (CAMH) Five Steps to Save a Life card
 - HHS Using Your Take Home Naloxone Kit pamphlet
 - HAMHC Community Resource pamphlet
- Eastern Health, the Department of Health and the AIDS Committee of Newfoundland & Labrador partnered to provide 1200 take home kits to 90 sites across the province. Training was provided via webinars to key contacts and other interested parties in advance of the roll-out. To date these sites have distributed approximately 269 kits to individuals and/or their families and friends. Discussions towards expanding the locations where these kits can be accessed are ongoing.

A complete overview of harm reduction activities submitted by HealthCareCAN members and partners can be found in Appendix 1.

1.2 Prevention and Surveillance

In the second part of the discussion on leading practices, participants focused on best practices for prevention of improper opioid use that can lead to opioid use disorders. Participants stressed the importance of working with addictions specialists, family physicians and health educators to ensure that new guidelines take account of a given patient's history with opioids. Appropriate treatment will differ depending on whether a patient is opioid-naïve, a first-time user of opioids for acute pain relief (eg. post-surgical analgesia), or a long-time user of opioids who routinely receives high doses.

Leading practices intended to prevent new addictions were submitted by a number of HealthCareCAN members. Actions in this area fell into six main categories:

Pain management

- The Yukon Hospital Corporation has convened a task force on pain management and trauma informed care. This group's priorities include: increasing the use of nonopioid medications; encouraging the use of non-medical approaches through collaborative clinics; and greater use of physiotherapy, massage therapy, exercises etc.
- The Inter-Professional Spine Assessment and Education Clinic (UHN) (ISAEC, www.ISAEC.org) was established in Ontario (pilot sites in Toronto, Hamilton, and Thunder Bay) in November 2012 with funding from the Ontario Ministry of Health and Long-Term Care. ISAEC's purpose is to enable shared care management of lower-back pain (LBP) by employing a network structure between primary care providers (PCPs: medical doctors and nurse practitioners), advanced practice clinicians (APCs, specially trained physiotherapists and chiropractors) and specialists (surgical, pain, and rheumatology). The model allows clinicians to deliver timely access to: evidence-based LBP assessment and risk stratification, care recommendations, education, and support to enable patient self-management of LBP. The program has successfully reduced the escalation of opioid dependency in LBP.
- The IWK Health Centre- Paediatric Pain Management Program works in collaboration with pediatricians, surgeons, and family doctors to manage children's pain after surgery or injury, and pain caused by cancer, infections, arthritis, or other illnesses. The Pediatric Complex Pain Clinic treats outpatients with chronic pain. Assessments and treatment are provided by a team including a physician, a clinical nurse specialist, a clinical psychologist, and a physiotherapist. Treatment often includes a combination of physical treatment and exercise, cognitive-behavioural techniques such as relaxation and imagery, and medications.

Medication management

- In May 2017 stakeholders including the [BC College of Family Physicians](#), [Regional Health Authorities](#), [Pain BC](#), the [College of Physicians and Surgeons of BC](#), and the [BC Centre on Substance use](#), met to discuss the implementation of the new National guidelines for Opioid Therapy and Non-Cancer Pain.
- [St. Michael's Hospital](#) in Toronto regularly employs addictions assessments in attempts to prevent addiction. Physicians with patients taking morphine equivalents greater than 200mg or those with unclear indications for opioid prescribing are asked to refer for an assessment. For people presenting for surgery who might at risk for addiction, the patient is seen pre-operatively, perioperatively, and during the transition to the community.

Safe handling of opioids

- Children most often obtain prescription opioid drugs in the home, whether their own or a friend's. Unused prescription opioids are often left in the home following orthopaedic surgery or acute orthopaedic injury (e.g. fracture). Given that a substantial proportion of the orthopaedic patient population receives opioid prescriptions, there exists an opportunity to effect safer opioid storage, and disposal by targeting this group directly. The [UHN's Orthopaedic Opioid Safety Project](#) (pilot project currently in development and planning phase) is designed to assess the impact of an education program along these lines. The education program is aimed at enabling orthopaedic surgeons, trainees, frontline clinical staff (e.g. nurses and technicians) and clerical staff to promote safe use, storage, and disposal of prescription opioids among patients, including facilitating the return of unused opioids to UHN's on-site outpatient pharmacy as part of routine clinical care. If the program proves successful, UHN will have strong grounds to expand the program to all surgical divisions within the network.
- At [Hamilton Health Sciences](#) The concept of Opioid Stewardship has been approved by the Medical Advisory Committee based on the following recommendation from the Pharmacy & Therapeutics Committee: "The Pharmacy and Therapeutics Committee recommends to the Medical Advisory Committee the development and implementation of a broad assessment and evaluation plan of the prescribing practices of opioids by practitioners at HHSC in line with the comprehensive provincial and federal opioid strategies to tackle opioid addiction and overdose".

Education

- [Eastern Health](#) has developed a mandatory safe prescribing course in collaboration with the College of Physicians and Surgeons of Newfoundland & Labrador and the Memorial University Faculty of Medicine. The course focuses on safe/appropriate prescribing practices for opioids, stimulants and benzodiazepines and is mandatory for all new physicians.
- [Island Health's Harm Reduction Services](#), [local School Districts](#), and the [Centre for Addiction Research \(CARBC\)](#) have been working in partnership to develop and implement community dialogues with both parents and school staff.

Analytics

- [The First Nations Health Authority](#) has established agreements with both provincial and regional stakeholders to access First Nations / Aboriginal specific data. A preliminary analysis of First Nations overdose data obtained through a data linkage between the First Nations Client File and data from the Ministry of Health, the BC Centre for Disease Control, and Health Authorities has been completed.

- **British Columbia Emergency Health Services (BCEHS)** provides detailed data on overdose calls to the BC Centre for Disease Control who in turn shares this data with the Joint Task Force partners. BCEHS also uses “real time” data, available on mobile devices to enable dispatch and supervisory staff to enhance adequate deployment of resources.
- Surveillance data show that there are periodic increases in volume of overdoses, both predictable and unpredictable. **Fraser Health** has implemented a community surge protocol to place an increased level of overdose intervention in high risk areas of the community. “Heat mapping” assists in identifying neighbourhoods with increased overdose presentations so the surge resources might best target their interventions.
- **Vancouver Coastal** has an overdose surveillance system that integrates overdose information from urban emergency departments, Insite VCH rural hospitals, BC Children’s Hospital, the Mobile Medical Unit during its deployment in the Downtown Eastside, the Dr. Peter Centre and all the Overdose Prevention Sites. Additionally, VCH holds information sharing agreements with partner agencies to obtain additional information not held by public health authorities. This data allows VCH to better characterize the affected population and develop more targeted services.
- **Alberta Health Services** has developed an Opioid Surveillance Dashboard which utilizes existing data in AHS (from EMS, EDs, Healthlink, etc.) and converts it into an easy visual format using Tableau. The dashboard accounts for opioid related-deaths, HealthLink calls, ED visits, hospitalizations, and EMS responses. Data in the dashboard are updated daily, weekly, and monthly. A publicly available version for sharing surveillance information with partners outside AHS is being developed.

Participation in collaboratives and meetings

- **Fraser Health** held BC’s first health authority-hosted hackathon, inviting programmers, developers, coders and students involved in technology and software development find solutions for some of our most pressing challenges. The Hackathon took place January 21 and 22 at Simon Fraser University’s Surrey campus with a number of promising solutions were developed over a 48 hour period. 3/9 challenges were related to the overdose emergency: 1) Take Home Naloxone App (<https://www.healthhackathon.ca/themes/theme6.html>); 2) Overdose analytics (<https://www.healthhackathon.ca/themes/theme7.html>); and 3) Mental Health and Substance Use services (<https://www.healthhackathon.ca/themes/theme8.html>).
- **The Canadian Centre on Substance Use and Addiction** partnered with Health Canada to host the national Opioid Conference and Summit in November 2016. The summit resulted in a joint statement of action with commitments from stakeholders across the country. CCSA continues to monitor implementation of these commitments, including seeking additional partners to join the fight against harms associated with opioids.

A complete overview of the prevention and surveillance activities submitted by HealthCareCAN members and partners can be found in Appendix 2.

1.3 Treatment

Treatment of opioid addiction was the final category of leading practices discussed at the roundtable. Participants noted shortages in services for people with opioid use disorder and the need to better integrate addiction and mental health services. To support this discussion, HealthCareCAN received a number of submissions regarding innovations in treatment. A selection of these are highlighted below. Actions in this area fell under four main approaches.

Opioid agonist treatment

- In the **Fraser Health region**, patients presenting to the ED with opioid use disorder have the option of being inducted on buprenorphine/naloxone then referred to an outpatient opioid agonist treatment clinic for stabilization.
- **Crosstown clinic operated by Providence Health**, was the first clinic in Canada to offer supervised injectable opioid agonist treatment and is still the only clinic providing prescription heroin. For a small number of people this is the only treatment that will attract them into care.
- In March 2017, **Vancouver Coastal health** opened the Downtown Connections Clinic which is aimed at increasing the uptake of OAT and at transitioning clients to established primary care services after a stabilization period. Since opening, 250 patients have started OAT therapy. In addition, 50 post-OD clients from ambulance services were accepted to Connections, thereby averting unnecessary ER visits.
- **The Sioux Lookout First Nations Health Authority (SLFNHA)** represents and serves over 30 First Nations communities in Northwestern Ontario, the majority of which are remote, fly-in communities. Programs providing opioid substitution therapy with buprenorphine-naloxone (Suboxone) and psychosocial supports including land-based and cultural activities now exist in over twenty communities, with over 1400 participants (up to 41% of adults in some communities are receiving treatment). In most cases, induction and stabilization on OST take place in-community under the supervision of visiting physicians, then ongoing DOT is provided by community addictions workers. This is accompanied by community-driven culturally-appropriate programming, particularly as part of an intensive induction month.

Addiction treatment resources

- **Island Health** has added 42 net new supportive recovery treatment beds added across Vancouver Island, including five stabilization beds to support post-detox care. They have also added a Rapid Access Addiction Clinic in Victoria to increase capacity and provide timely access for clients seeking OAT or methadone treatment. This service links to other community services and ensures smooth transitions for clients as they move through recovery and treatment programs.
- **Sick Kids' Adolescent Substance Abuse program** provides Day Treatment Services and Outpatient Services for teens up to 18 years of age. Through both services the program provides:
 - Assessment and treatment for teens up to 18 years of age.
 - A parent program and support for families or guardians of teens in the program
 - Comprehensive health assessment and medical follow-up as needed.
 - Education about adolescent alcohol and substance use and abuse.
- In **New Brunswick**, the **Department of Health is working in collaboration with the two regional health networks, Horizon and Vitalité**, and key stakeholders to develop a plan to enhance addiction and mental health services in New Brunswick. Part of this work involves reviewing the current Addiction and Mental Health programs and services along the existing continuum of care, reviewing best and promising practices in the literature and in other jurisdictions, and developing a plan to ensure that New Brunswick's continuum of services in addiction and mental health are aligned with best practices.

Development of new integrative care models

- **Alberta Health Services** has been working to integrate opioid dependency treatment (ODT) and primary care. Distinct partnerships (two) have been established bringing together primary care clinics, including family physicians and their teams, with specialty ODT programs and experts to support and identify opportunities for the delivery ODT in primary care. Beginning as a proof of concept, there is intent to build toward model that can be used throughout Alberta.
- **St. Michael's Hospital** has developed an Integrated Model of Care for Substance Use and Harm Reduction. The day-to-day clinical team serves as a clearinghouse for addiction in the hospital and consists of addiction experts from family medicine, psychiatry, internal medicine and emergency medicine. In addition, patients are seen by and cases discussed with our case managers, nurse practitioners and, peer support workers with lived addiction experience.
- **The Royal Ottawa** has developed a Regional Opioid Intervention Service (ROIS). ROIS's multidisciplinary team provides outpatient treatment for opioid use disorders, alongside treating mental health problems. ROIS is a collaborative hub and spoke partnership, which integrates a clinic at The Royal with a network of community, hospital and primary care service providers to offer patients a full spectrum of care. ROIS also has a strong partnership with Ottawa Public Health, with a focus on harm reduction and overdose prevention and response. ROIS utilizes technology, including telemedicine services, to both deliver patient care and work collaboratively with providers to build capacity.
- In 2012, **the Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction and the Canadian Executive Council on Addiction** created a partnership to research and build consensus on effective strategies for collaboration between mental health and addiction services. A best advice document, "Collaboration for Addiction and Mental Health Care: Best Advice", was published in 2014. It was updated in 2015 with additional examples of good practices in collaboration in addiction and mental health care.

Training of health care providers and first responders

- **The British Columbia Centre on Substance Use** has developed fellowship training programs for physicians and nurse practitioners in the area of addiction medicine. They have also developed new guidelines on the clinical management of opioid use disorder.
- **Vancouver Coastal Health, through the Department of Family and Community Practice, has partnered with the newly created BC Centre on Substance Use (BCCSU)** to provide opportunities for physicians across VCH. These opportunities include workshops (22 MD and 7 NPs have attended) and a two-week preceptorship training program (6 MDs already enrolled) to improve knowledge, skills, and capacity to prescribe methadone and Suboxone®.
- **Alberta Health Services** has created an Opioid Dependency Treatment Network which facilitates mentoring, consultation, and educational opportunities between opioid dependency treatment (ODT) experts and those with little experience.

A complete overview of the treatment activities submitted by HealthCareCAN members and partners can be found in Appendix 3.

SECTION 2: ONGOING CHALLENGES FOR HEALTHCARE *CAN* MEMBERS AND PARTNERS IN ADDRESSING THE OPIOID CRISIS

HealthCare*CAN* members and partners have taken action in the realms of harm reduction, prevention and surveillance, and treatment of opioid use disorders. Yet hospitals and health care organizations continue to face challenges in the response to the opioid crisis. This section highlights those barriers to progress that were raised in advance of the roundtable, and at the roundtable itself. Some of these challenges can be addressed through the efforts of hospitals and healthcare organizations themselves. Other, more systemic barriers will require a coordinated intervention from governments and a wide range of health system stakeholders.

2.1 Harm Reduction

1. Harm reduction services are unavailable in some areas

There continues to be a lack of equitable, easy, and quick access to naloxone and education about overdose prevention and response. In many areas, harm reduction practices are not consistently integrated within all addiction treatment programs (especially residential treatment programs), which puts individuals at risk for overdose and other harms (i.e., HIV, hepatitis C, STIs).

2. Opioid users face ongoing stigma

There is a high degree of stigma associated with substance use. As a result, addictions are under-reported and sufferers are often reluctant to access services for fear of discrimination. Reducing this stigma will be necessary in addressing the crisis moving forward.

2.2 Prevention and Surveillance

3. The need for a greater focus on prevention of addiction

Initial crisis responses were focused on harm reduction. While this needs continued support, additional resources must be directed at the prevention of opioid addiction. Efforts must be made to identify at risk patients; improve medication management; and increase access to effective pain management strategies including alternative therapies such as physiotherapy, occupational therapy etc. to prevent new patients from becoming addicted to opioids.

4. Prescription, addiction and overdose surveillance capacity is limited

Members highlighted the need for a national surveillance network to research the impact of any measures introduced to address the opioid challenge and to use data to improve care strategies as necessary. While opioids are the current focus, this epidemic has taught us that we are ill-prepared for any epidemic of emerging drugs of abuse. It will be necessary to develop systems that can monitor and respond to increases in use of both prescribed and illicit drugs.

2.3 Treatment

5. Treatments and services for people with opioid use disorders are insufficiently integrated

There needs to be greater integration between mental health and substance abuse services recognizing that both require adequate funding and resources. The identification, assessment and management of opioid use disorders must also be integrated within primary care settings and other locations throughout the health sector. There are challenges in coordination among all levels of government and the different provider groups.

6. There is no system of care for opioid disorder treatment services

Although the opiate crisis has increased access to necessary measures such as opioid agonist treatment and naloxone kits, access to appropriate and evidence-based psychosocial interventions has fallen far behind. It remains as hard as ever for patients with addiction or at high risk of addiction to receive appropriate assessment and concurrent treatment for mental health conditions, pain and trauma. People with opioid use disorders presenting to hospital Emergency Departments (ED) for opioid overdose, withdrawal, or other harms, do not have rapid, seamless access to care direct from the ED. Additionally, there is insufficient capacity in the primary health care system to meet the needs of those living with substance use problems. Patients should be able to access ongoing, evidence-based treatment, peer-support, and secular support for their substance use disorder. Furthermore, privatized addictions services are working in silos and there is limited control over quality and safety in these programs.

7. Indigenous populations have unique needs

The **First Nations Health Authority** in collaboration with provincial and regional partners has developed a surveillance protocol to monitor the opioid crisis among First Nations populations in British Columbia. Preliminary analysis of this data suggests a disproportionate impact of both overdoses and deaths on First Nations, highlighting the need for a prompt and specialized approach, including implementation of a wide variety of culturally-safe and trauma-informed interventions that would meet the needs of First Nations.

8. The needs of the Paediatric population must be considered

There are certain aspects of the opioid epidemic which are unique, almost exclusive, to the vulnerable pediatric population. Young children risk of accidental exposure to opioids prescribed to family members. There is also an unmet need for enhanced and harmonized best practices in Canada in terms of opioid treatment of chronic pain in children - an issue which was regrettably not addressed in both the recent CDC and Canadian guidelines of opioid treatment of non-cancer pain. Most of all, children lack access to well-trained interdisciplinary teams to provide the multiple modalities of non-pharmacological and pharmacological care required to prevent and control chronic and neuropathic pain. Other challenges include the increased rate of birth of addicted neonates to mothers using opioids, and concerns around optimal and long-term care of addicted adolescents.

9. A lack of awareness regarding opioid use management during pregnancy

There needs to be better education about the perinatal management of people with opioid use disorder. Additionally, education around complicated withdrawal (pregnancy, comorbid conditions, codependent substances) must be increased. Currently there is public health knowledge in regard to alcohol in pregnancy, we recommend there should be public health education with respect to opiates in pregnancy.

10. Education and professional development of care providers are key considerations

Health care providers are challenged to translate the various recommendations into practice. There is a need for coordinated continuing professional development that 1) addresses the practical aspects of managing opioid dependency, 2) addresses the current climate of fear amongst physicians and the assumption that all opioid use is addiction or misuse, and 3) guides safe maintenance and intermittent use prescribing. In addition, to courses and guidelines, the modeling of appropriate behaviour by health care providers experienced in managing opioid addictions and treatment must be included in CPD activities.

SECTION 3: ADDRESSING THE OPIOID CHALLENGE ON A GO-FORWARD BASIS – POTENTIAL ACTIONS BY HEALTHCARE CAN MEMBERS

3.1 Commitments

HealthCareCAN is committed to doing everything it can to contribute to the collaborative response to the opioid crisis. HealthCareCAN is proud to be a signatory of the [Joint Statement of Action to Address the Opioid Crisis](#).

As a signatory, HealthCareCAN has made the following commitments:

- **By May 2017:** Establishing and working with existing public health and healthcare networks to convene meetings of members to facilitate the sharing of best practices, including, but not limited to, surveillance, treatment, and overdose prevention.
- **By June 2017:** Holding a town hall forum on Opioids at the National Health Leadership Conference in Vancouver. This conference is attended by more than 700 health system leaders and those working at the front lines of Canadian healthcare.
- **By December 2017:** Working with members to leverage and share education programs about the dangers of handling fentanyl and carfentanil for first responders.
- **By December 2017:** Working with academic health sciences centres and other partners to identify a best practice curriculum on pain management and opioid related disorders.
- **By December 2018:** Once identified, working with members to roll out this curriculum to healthcare providers across the country. As many initial addictions start in hospital, there is a need to ensure that hospital based providers are current on pain management best practices.
- **On an ongoing basis:** Working with Health Canada, the Canadian Society of Hospital Pharmacists, other stakeholders and our members to identify best practices related to the handling and monitoring of medications within hospital, with the aim of reducing the loss and theft of opioid medications.
- **On an ongoing basis:** Working with Health Canada and our members to ensure real-time alerts and the surveillance of opioid drugs and analogues within and outside of Canada.
- **On an ongoing basis:** Ensuring interaction between our members and the Canadian Institute for Health Information (CIHI) to aid in improving timeliness and accuracy of data regarding adverse opioid related health events requiring hospital based assessment and treatment.

3.2 Supplementary Options

These commitments notwithstanding, participants acknowledged that the health sector as a whole needs to do more to combat the opioid crisis in Canada. With this in mind, HealthCareCAN members identified a set of potential supplementary actions for the group's consideration. These are not approved commitments, but instead are included below to focus discussions going forward on how major health system players and stakeholders can collaborate to address the crisis going forward.

Harm Reduction

- Commit to working with health care organizations and hospitals to de-stigmatize addiction. Develop compassion/stigma reduction modules for clinical positions that regularly interact with people at risk.
- Commit to working with organizations and partners to increase equitable, easy, and quick access to naloxone and overdose prevention and response services.
- Consider the misuse of benzodiazepines in any strategy to address the opioid crisis as many patients are also misusing these medications.

Prevention and Surveillance

- Commit to developing programs for pain management and increasing access to non-opioid treatment of pain such as physiotherapy.
- Commit to limiting the length of prescription for patients discharged with opioids after surgery.
- Commit to improving ways to recognize/record substance use disorders in hospitals. This could include adding a "tick box" to triage for all visits about "was this presentation related to substance use" that will be extracted and available in NACRS.
- Increase the reporting of opioid overdoses and deaths- in line with initiatives in many provinces/territories
- Increase screening and clinical interventions for target population (19-49 men) to identify illicit drug use.
- Commit to "opioid stewardship" akin to "antimicrobial stewardship". The creation of a web portal with tools and resources for clinicians would contribute to the goals of preventing and reducing the harms associated with opioids.

Treatment

- Commit to the adoption, implementation, and enforcement of the delivery of evidence based interventions (including access to opioid agonist therapy) for people with opioid use disorders who are receiving services in the hospital/healthcare setting. This may require the development of a best practice curriculum or training for healthcare providers.
- Commit to offering to all patients with substance use disorders, treatment and/or harm reduction services in hospital for their substance use disorder regardless of whether they request it. This could include a multi-disciplinary inpatient consultation service with peer-support workers in every hospital. When someone has a heart attack they see cardiology. The same should occur with overdoses.
- Commit to improving education about the perinatal management of people with opioid use disorders. There needs to be added education around complicated withdrawal (pregnancy, comorbid conditions, codependent substances). Increased awareness that treatment of withdrawal in pregnancy is a medical emergency.

- Commit to synchronizing the various guidelines and practices to support health care providers in most effectively treating people with opioid addiction or who are at risk of addiction.
- Commit to working with organizations and partners to break down system silos and foster the integration of mental health and addiction services to improve outcomes for people with opioid use disorders.
- Commit to increasing rapid access to addiction medicine clinics. These clinics should offer psychosocial interventions onsite or rapid access to psychosocial interventions.
- Commit to developing peer support networks and counselling positions within hospitals and health regions.

CONCLUSION

Canada's opioid crisis continues to have devastating impacts on the health and well-being of Canadians, as evidenced by the large and growing number of hospitalizations and deaths attributable to opioid abuse. Tackling this public health emergency will require commitment from all affected parties from the Provincial/Territorial and Federal governments to front-line practitioners and first responders.

The actions highlighted in this report represent the steps that HealthCare*CAN* members and partners have taken to address the crisis in their jurisdictions. While much needed action is underway, there remain critical challenges that need to be met to ensure success in turning the tide of harms associated with opioid use.

The Ministerial roundtable held June 12th underscored the importance of connections, and working together to address the crisis. Participants emphasized the importance of sharing and scaling best practices from across Canada. HealthCare*CAN* is committed to taking necessary steps to support the Minister and Health Canada staff in moving the agenda forward. We are also committed to supporting our members in calling for necessary supports, and in establishing necessary collaborations. HealthCare*CAN* will work with Health Canada and its members to formalize a process to facilitate the sharing of best practices on a go forward basis. Together we can seek to reduce the harms associated with opioid use in Canada.

APPENDIX 1: LEADING PRACTICES – HARM REDUCTION

Yukon Hospital Corporation

Yukon's approach is organized and facilitated by the Chief Medical Officer of Health –Dr. Brendan Hanley. The approach is four-pronged: 1) Education 2) Communication 3) Harm Reduction 4) Pain Management. All four groups had vast and extensive representation from Health & Social Services Departments, Yukon Hospitals, RCMP, Emergency Medical Services, First Nations, Outreach, NGO's.

Education: started first with information dissemination to all groups, including a conference: Preventing & Managing Opioid Addiction/Misuse Through Innovative Models of Care. Unique issue: couldn't produce local stats as lab urine dips were not specific for Fentanyl –resolved in late 2016 and now able to provide meaningful data to engage parties.

Communication Group: started in Sept. 2016 with partner involvement on public communication campaign - posters throughout bars, businesses, communities. Ads in papers, newsletters, and ads on local TV, social media

Harm Reduction: Naloxone Kits and 'Don't Use Alone' campaign

Three sites as pilot in late 2016: Tiaga Referred Care Clinic (for people without family doctors who are deemed to be high risk/marginalized), Blood Ties Four Directions Outreach, and First Nations Health Centre

Other sites added in early in 2017: Pharmacies, Yukon Hospitals Emergency Departments, Alcohol & Drug Services (Detox), and the rural Community Health Centres.

The kits are distributed with training on overdose recognition and essential steps. In terms of demographics; Kits: 51% First Nations: 49% nonFN; 39% Male: 61% Female

British Columbia Emergency Health Services

BC Emergency Health Services (BCEHS) provides emergency pre-hospital care and inter-facility care throughout the province of B.C. BCEHS responded to over 19,000 overdose calls in 2016. BCEHS has implemented a number of strategies to enhance the response to the opioid crises. These include:

- Training firefighters across the province to administer naloxone to ensure a timely response to overdose patients should firefighters arrive at a scene first.
- Working collaboratively with community services, NGO's to ensure they are equipped and able to administer oxygen, naloxone during an overdose event.
- Placing stationary 'medical support units' in some high overdose locations including the downtown eastside of Vancouver to reduce transportation time to calls.
- Placing special units that act as a resupply station for paramedics during high overdose calls times, especially during income assistance cheque distribution week when we see a spike in calls.
- Providing paramedics with more flexible modes of transportation. Paramedics use bicycles and ATVs in high overdose areas to respond to medical emergencies more rapidly. Bikes and ATVs are often used by teams of

paramedics in areas that are difficult to navigate through in an ambulance. (i.e. alleys, between buildings, pedestrian areas.)

- Providing supervisory support to assist paramedics and dispatchers with triaging and more efficient patient handover at busy hospital emergencies, so ambulances can get back on the road more quickly to respond to other calls.
- Expanding the Dispatch Centre's ability to monitor and triage complex cases to further support paramedics.
- Deploying single responder, advanced care paramedics/specialists, who respond to overdose calls alone in SUV's, increasing capacity, and who can respond to calls when other paramedic crews encounter a difficult to resuscitate patient.
- Establishing criteria, used successfully in Europe, to determine which patients do not require transport to hospital, after being resuscitated, avoiding unnecessary transports and the delay in getting paramedics back on to the street. These patients, if willing, are transported to clinics, the Mobile Medical Unit and /or other addiction services.
- Providing resiliency training and counseling for paramedics and other first responders to mitigate the risk of psychological injury and PTSD.

British Columbia Mental Health and Substance Use Services

BC Mental health & Substance Use Services (BCMHSUS) provides tertiary and quaternary inpatient and community based assessment and treatment services for those with mental health and substance use disorders.

Management of overdose:

- Naloxone administered by physicians, Nurse Practitioner or nurses.
- All patients/clients provided with education and naloxone kits upon discharge and when on day leave

First Nations Health Authority

Practice: Raising Awareness—Naloxone and Harm Reduction Sessions

FNHA is working closely with BC health system partners to raise awareness on how to reverse overdoses through Naloxone and the types of harm reduction services are available.

Development/implementation: FNHA is working with the BC Centre for Disease Control to integrate access to Naloxone training and kits for First Nations communities as a component of the provincial response to the overdose crisis. In addition, FNHA Indigenous Wellness Team has created and delivered a variety of harm reduction sessions that honour traditional knowledge specific to First Nations in BC.

In order to reduce cultural stigma and make harm reduction services more culturally safe, a Compassion, Inclusion and Engagement (CIE) partnership has been developed with the BC Centre for Disease Control, Health Authorities, First Nations, people who have lived experience with illicit substance use, and community service providers to engage in collaborative dialogue, planning and action. CIE sessions offer information and education on cultural safety and humility, and trauma-informed care, with the goal of increasing acceptability and accessibility of services by people with problematic substance use issues.

Initial Results:

- Over 110 First Nations communities in BC have been trained to administer and distribute Naloxone. To date over 1,015 orders for Naloxone kits have been placed through 72 primary sites.
- FNHA delivering a variety of harm reduction sessions that honour traditional knowledge specific to BC First Nations. Harm Reduction workshop topics include: Harm Reduction 101; Indigenizing Harm Reduction; Decolonizing Addiction; and, Take Home Naloxone training program.
- FNHA has held eight town hall meeting in communities across the province to share information and support hands-on learning about the opioid crisis.
- CIE sessions have occurred in three regions (North, Interior, Fraser) with plans for Vancouver Island underway. The sessions have recruited 57 peers and 73 service providers, as well as managers representing 10 communities, three health authorities and nine community organizations.

Fraser Health Authority

Supervised Consumption Services (SCS) and Opioid Agonist Treatment (OAT) integration: Findings from the scientific evaluation of supervised injection services at Insite in Vancouver demonstrate that among people who use drugs, those attending Insite have a significantly increased likelihood of engaging in treatment for substance use. In order to take greatest advantage of this benefit of supervised consumption services, Fraser Health has designed its first two SCS to have OAT immediately available to those who wish to initiate treatment and are eligible. At SafePoint (135A Street, Surrey) rapid access OAT has been implemented at the adjacent SHOP clinic. At Quibble Creek Sobering and Assessment Centre, where SCS is being implemented as part of standard practice, rapid access OAT has been implemented at the substance use clinic in the same building. Referral and uptake of this unique arrangement of services, strengthening the continuum of care, will be evaluated.

Interior Health

Mobile Overdose prevention site: Interior Health's mobile overdose prevention unit is a motor home fully equipped to assist intravenous drug users in case they overdose. The program runs Tuesday-Saturday and operates from 12:30-5:30; and 7:00-11:30pm at two different sites in the Kelowna. Services provided include: outreach to surrounding area, overdose prevention and response, naloxone kits, harm reduction supplies, primary care (wound, foot and burn care services), counselling and referral to treatment and other medical services. A similar unit will be available in Kamloops shortly.

Island Health

Concrete actions to reduce harm

- Embedded and expanded needle exchange services in front-line Island Health and community agency locations (e.g. Public Health Units, Mental Health and Substance Use services and Non-Governmental Organizations) to provide multiple, accessible locations for clean supplies. Supplies are available in over 20+ locations on Southern Vancouver Island alone.
- Opened six Overdose Prevention Units across Vancouver Island to provide harm reduction supplies, timely intervention in the event of overdose, peer supports and connections to other services.

- Submitted an application for Supervised Consumption Service in Victoria with two more applications pending in Victoria and Nanaimo. The pending applications will both be embedded in a residential model that provides housing for higher risk populations - a new and novel approach to Supervised Consumption Services in Canada.
- Expanded and enhanced Naloxone kit distribution and training targeted at high risk groups/individuals, community agency service providers and Island Health staff in Mental Health and Substance Use Services, Emergency Departments, etc.
- Enhanced Integrated Mobile Crisis Response Team (Victoria) and Central Island Crisis Response to include response to opioid overdoses.
- Expanded community outreach workers through contracts with agencies which serve drug-using populations to conduct education, outreach and connectivity in housed and non-housed populations.

Vancouver Coastal Health

The two main harm reduction strategies employed by VCH have been expanding community access to naloxone and increasing availability of supervised injection and overdose prevention services. We have increased community naloxone access by increasing the number and types of sites dispensing Take Home Naloxone kits to people at risk of overdose and have provided Facility Overdose Response Boxes to community agencies working with clients at risk of overdose.

VCH operates two supervised injection sites and has applied to establish two new sites. Federal approval is pending despite the emergency. A provincial ministerial order has allowed VCH to establish 5 Overdose Prevention Sites greatly increasing access to supervised injection services with our region. These sites together are now seeing more visits than Insite and reversing a significant number of community overdoses. There have been no deaths or problems with public order related to these sites calling into question the need for a federal approval process for such services.

A leading practice in this area is the provision of drug checking services. Data from Insite demonstrated that clients who's drugs tested positive for fentanyl were more likely to reduce their dose and less likely to overdose. VCH is now in the process of determining how to expand community access to drug checking services.

Alberta Health Services

Take Home Naloxone(THN) Program

Overview of the practice: To ensure free take home naloxone (THN) kits are available to AB residents throughout the province. The program is funded by AB Health and centrally operated through AHS. Distribution occurs through AHS facilities, community pharmacies and community organizations (eg. Alberta Community Council on HIV (ACCH)).

How practice was developed and implemented: The Province-wide THN program was developed through engagement with diverse partners. The program required creating new partnerships with harm reduction agencies and community pharmacies and was a factor in descheduling naloxone in Alberta (making it available without prescription).

Initial results/next steps: Currently 17,017 THN kits have been dispensed and 1,309 overdose reversals reported from July 2015 to April 30, 2017. Over 1,132 sites can dispense THN kits.

Winnipeg Regional Health Authority

Across the province there are now 42 registered naloxone distribution sites, including First Nations communities. Efforts continue to scale up the distribution network.

Enhancing support for overdose early detection: specifically for public washrooms where people may use drugs. The Human Sexuality and Harm Reduction program piloted a door lock that is timed for 10 minutes before an external light goes on to signal staff to knock on the door etc. Of course there is a policy to accompany safe use of our facility washroom. A number of other Winnipeg sites are installing this technology (Main Street Project, RAY, Aboriginal Health and Wellness). This is a novel and inexpensive intervention that was shared by Fraser Health and works well in places where supervised consumption services are not indicated, available or feasible. This way if a person overdoses on site he/she will be found early enough to have their overdose reversed. We don't have a lot of incidents so evaluating this is a challenge.

Hamilton Health Sciences

Availability of Naloxone Rescue Kits in HHS Emergency Departments

Overview of the practice: Patient inclusion criteria for the kit include patients presenting in the Emergency Department as a substance abuse overdose and being discharged home or a known substance abuse patient presenting to the Emergency Department with complications from drug use. The patient must be assessed by an Emergency Department physician and deemed appropriate for naloxone rescue kit dispensing. Electronic documentation of dispensing and patient education occurs in the hospital information system.

How it was developed and implemented: Naloxone rescue kits were made available to community pharmacies only initially by the provincial government. The need for availability in the hospital setting was recognized by Emergency Department clinicians and others at HHS. Sourcing of a Naloxone kit was undertaken by the Director of Pharmacy so that the kits were made available in December 2016.

A comprehensive training program for all Emergency Department staff has been undertaken. Educational materials have been developed for staff and patients. Patient instructions and educational materials include:

- Centre for Addiction and Mental Health (CAMH) Five Steps to Save a Life card
- HHS Using Your Take Home Naloxone Kit pamphlet
- HAMHC Community Resource pamphlet

Formal launch of the program is June 26, 2017.

Vitalité Health Network

There has been increasing numbers of fatal and non-fatal opioid poisonings in Canada, with some jurisdictions declaring a public health emergency. With this emerging issue, it is necessary for the Department of Health to ensure measures are in place for the prevention and response to opioid poisoning.

Problematic substance use resulting in premature death and its related health issues has a significant effect on the economy through its direct impact and indirect impact on the healthcare and criminal justice systems and loss of productivity.

Naloxone

- Naloxone is a drug used to temporarily reverse the effects of opioid overdose and can save lives in overdose situations.
- Most first responders in the province, including Ambulance New Brunswick, most municipal police forces and the RCMP, have been equipped with, and are qualified to administer, this drug.
- We continue to monitor the situation in NB and consulting with other jurisdictions to better understand the challenges they are facing and the lessons learned.
- We are developing recommendations as it relates to the use and distribution of naloxone.

Eastern Health

Take Home Naloxone Kit Program: Eastern Health, the Department of Health and the AIDS Committee of NL (who operate the provincial needle exchange and other harm reduction programs) partnered to provide 1200 take home kits to 90 sites across the province. Training was provided via webinars to kit contacts and other interested parties in advance of the roll out. To date, these sites have distributed approximately 269 kits to individuals and/or their families and friends. Eastern Health's Research Department is monitoring the distribution for evaluation purposes. A provincial Advisory Committee was established in May and discussions are ongoing as to the expansion of this program to include emergency departments and pharmacies.

Public Awareness/education campaign: A multi-faceted campaign focused on opioid overdose awareness and naloxone was launched the week of May 29th. This campaign, which consists of posters, social media advertising, movie theatre advertising and wallet cards, will run for approximately 6 weeks.

City of St. John's Fentanyl Action Group: The City of St. John's, Eastern Health, the Department of Health & Community Services and a number of community based organizations partnered to develop a response to the growing concerns related to fentanyl use in the capital city. As part of this plan, this group announced its intentions to establish pop up sites at various city parks and festivals over the coming months. These pop up sites would enable the public to learn more about fentanyl and other opioids and to provide take home naloxone kits to those who may require it.

Surveillance: A Surveillance Working Group has been formed to collect, analyze and interpret qualitative and quantitative information regarding opioid overdoses and emerging issues related to opioids in NL. In April, 2017, Eastern Health issued a public advisory about an increase in the number of serious overdoses related to an opioid being sold as heroin in the St. John's metro area. Over a two- week period, Eastern Health became aware of approximately 15 reported overdoses, including at least one death.

Eastern Health Task Force: Eastern Health recently established an internal task force for the purpose of communicating and coordinating efforts taking place within the health authority. The membership is comprised of a cross representation of senior leaders across the organization and its focus will be on surveillance, education/awareness (staff and public), take home naloxone program and treatment.

APPENDIX 2: LEADING PRACTICES – PREVENTION AND SURVEILLANCE

Yukon Hospital Corporation

Yukon’s approach is organized and facilitated by the Chief Medical Officer of Health –Dr. Brendan Hanley. The approach is four-pronged: 1) Education 2) Communication 3) Harm Reduction 4) Pain Management.

The Task Force on Pain Management and Trauma Informed Care: Started in January 2017 with six priority areas

1. Care Delivery/Service Coordination: improve coordination, less patients ‘through the cracks’
2. Prescribing: guidelines for opioids. Use of suboxone –more education for prescribers
3. Maintenance/Monitoring: best opioid for maintenance. Monitoring standards –which to use
4. Screening: best, most efficient tools; use of urine drug screens.
5. Managing high-risk transitions: discharge from hospital; release from jail –supports, options
6. Prevention: use of nonopioid medications; use of non-medical approaches through collaborative clinics or just exploring options –chiropractor, massage therapy, physiotherapy, exercises, etc.

Issue: possibly the most effective way to prevent addictions is number 6. Why is it last? Canadian Medicare covers hospitals, doctors, and medications only.

British Columbia Emergency Health Services

BC Emergency Health Services (BCEHS) provides emergency pre-hospital care and inter-facility care throughout the province of B.C. BCEHS responded to over 19,000 overdose calls in 2016. BCEHS has implemented a number of strategies to enhance the response to the opioid crises. These include:

- Participating on the Joint Task Force on Opioid Prevention and Response, which was established following the declaration of a Public Health Emergency by BC’s Chief Medical officer.
- Providing detailed data on overdose calls to the BCCDC who in turn shares this data with the Joint Task Force partners. BCEHS also uses “real time” data, available on mobile devices to enable dispatch and supervisory staff to enhance adequate deployment of resources.

British Columbia College of Family Physicians

On May 12th 2017 the BCCFP held a meeting of provincial stakeholders to discuss the implementation of the new National Guidelines for Opioid Therapy and Chronic Non-Cancer Pain. Stakeholders present included the BC College of Family Physicians, Regional Health Authorities, Pain BC, the Provincial Health Officer, the College of Physicians and Surgeons of BC, the BC Centre on Substance Use, and Doctors of BC Section of Pain Medicine.

British Columbia Mental Health and Substance Use Services

BC Mental health & Substance Use Services (BCMHSUS) provides tertiary and quaternary inpatient and community based assessment and treatment services for those with mental health and substance use disorders.

The prevention of opioid addiction (e.g. pain management assessments; referral to physiotherapy or other allied health providers for management of non-cancer pain):

- The services below vary by acuity of need:
- Chronic pain psychotherapy and self-help group.
- Yoga, acupuncture, physiotherapy, art therapy, recreation therapy.
- Patients with opioid dependence – evidence based withdrawal management
- Non-opioid pain medication
- If opioid medication required, evidence based lowest dose regime used.
- Pain specialist (part-time) being recruited as consultant

First Nations Health Authority

The First Nations Health Authority (FNHA) has proactively accelerated actions to prevent, address and/or mitigate the impacts of overdoses and deaths related to the opioid crisis among First Nations. However, the issues of substance use are longstanding and connected with intergenerational trauma and colonization. FNHA recognizes the need for a long-term, cross-sectoral and partnered response consistent with cultural safety and humility, upstream interventions and trauma-informed care.

Practice: Partnerships

FNHA has been actively engaged with the provincial government on the opioid crisis in BC to effectively leverage and align efforts.

Development/Implementation: As the only pan-provincial health authority in Canada focused on First Nations health and wellness, FNHA is uniquely positioned to ensure that BC First Nations perspectives and priorities are hardwired within in the provincial response to the opioid crisis. This has been enabled through strong health governance partnerships with the Ministry of Health, Provincial Health Officer, all Health Authorities, and provincial partners such as the BC Centre for Disease Control.

Initial Results:

- FNHA is a key player in all provincial forums and committees associated with the opioid crisis. This includes FNHA's active participation in the provincial committee structure established to respond to the public health emergency and FNHA engagement in the senior committees within the health system in BC. It also includes meetings amongst senior officials specifically to advance priorities related to the First Nations population.
- FNHA and the Ministry of Health are actively partnering to align communication and social marketing ensure all activities take into consideration First Nations perspectives.

Practice: Data and Surveillance to Support Actions

FNHA is working with the Ministry of Health and Health Authorities to ensure that the evidence-base on opioid use and related harms, in particular overdose rates, is collected.

Development/Implementation: FNHA has established agreements with both provincial and regional stakeholders to access First Nations / Aboriginal specific data. A preliminary analysis of First Nations overdose data obtained through a data linkage between the First Nations Client File and data from the Ministry of Health, the BC Centre for Disease Control, and Health Authorities has been completed.

Initial Results: Preliminary analysis of the data suggests a disproportionate impact of both overdoses and deaths on First Nations, highlighting the need for a prompt and specialized approach, including implementation of a wide variety of culturally-safe and trauma-informed interventions that would meet the needs of First Nations. These approaches should pay equal attention to First Nations men and women, and target youth. Further analysis is continuing and next steps are being developed with the Provincial Health Officer, FNHA Chief Medical Officer and other senior health leaders.

Fraser Health Authority

Health Hackathon: Fraser Health held BC's first health authority-hosted hackathon, inviting programmers, developers, coders and students involved in technology and software development find solutions for some of our most pressing challenges. The Hackathon took place January 21 and 22 at Simon Fraser University's Surrey campus. By combining the creativity and passion of external participants with the depth and the breadth of experiences from Fraser Health, a number of promising solutions were developed over a 48 hour period. 3/9 challenges were related to the overdose emergency:

- 1) Take Home Naloxone App (<https://www.healthhackathon.ca/themes/theme6.html>);
- 2) Overdose analytics (<https://www.healthhackathon.ca/themes/theme7.html>); and
- 3) Mental Health and Substance Use services (<https://www.healthhackathon.ca/themes/theme8.html>).

Promising teams have been invited to further develop and finalize their solutions by working with Fraser Health Authority and Innovation Boulevard through an incubator to enable rapid prototyping and innovation. <https://www.healthhackathon.ca>.

Overdose Surge Response: Surveillance data show that there are periodic increases in volume of overdoses, both predictable (social assistance cheque issue week) and unpredictable (related to toxicity of the illicit drug supply). To assist with mediating the heightened risk of overdose death during these periods, Fraser Health has implemented a community surge protocol to place an increased level of overdose intervention in high risk areas of the community. "Heat mapping" assists in identifying neighbourhoods with increased overdose presentations during surge periods so the surge resources might best target their interventions which include, naloxone kit distribution, engagement and referrals to treatment, witnessing drug use, overdose reversal, increased access to overdose prevention sites and community engagement. Surge resources include public health nurses, mental health and substance use clinicians and outreach workers, emergency health services, St. John Ambulance, and community partners. Surge response is currently implemented on 4 days during cheque issue week in specific communities when sentinel surveillance identifies a spike in overdose presentations.

Community Based Response: Multi-sectoral and community based responses with representation from housing, community agencies, municipalities, fire dept., health, education and police have worked well in outreach efforts, meaningful communication and comprehensive local responses.

Compassion Campaign: Communication and public engagement campaign to reduce stigma related to substance use.

Shared Care Initiative: There are growing numbers of shared care initiatives involving FHA Addiction Medicine Specialists and Community Family Physicians. In this model, patients with opioid use disorder or on high dose opioid medications for chronic pain will see an FHA physician who will adjust their medications in line with current evidence and/or induct them onto buprenorphine/naloxone. Once stabilized, these patients are transferred to family physicians in the community who will continue their OAT prescriptions.

Island Health

Health Promotion, Prevention, Public Education and Health Literacy

- General public information and marketing campaigns in partnership with the Province of BC.
- Education and awareness presentations on reducing the risk of drug use and talking to youth about drug use in a 'non-scare tactic approach', targeted through the school system, vulnerable groups, educators and non-governmental organizations.
- Increased public health nursing, harm reduction coordinator and mental health and substance use clinician staffing levels to expand service reach across the service spectrum (i.e. from education through to treatment).
- Partnered with Island Health's Harm Reduction Services, local School Districts, and the Centre for Addiction Research (CARBC) in efforts to develop and implement community dialogues with both parents and school staff. The goal of these local discussions is to clarify the concerns, identify what is being done to address substance use, and provide a forum for discussion about what needs to be continued and improved. Think of this as the beginning of a process to address health promotion/prevention and early intervention. Although we include some talking and discussion points related to the opioid crisis, we are working towards more preventative steps and strategies re substance use with youth and their families.

Vancouver Coastal Health

VCH has identified adverse early childhood experiences, trauma, pain, social isolation and stigma as key drivers of the emergency and is trying to focus prevention efforts in these areas. Social isolation and stigma are particularly linked to overdose mortality in that the vast majority of people dying from overdose in our region are dying alone in private residences despite the availability of harm reduction services. VCH has been partnership with housing providers to developing housing-based interventions in an effort to address this issue.

A leading practice in this area has been to advocate for policies that seek to reduce stigma in people who use drugs. The most important of these are policies that seek to decriminalize and/or legalize drugs. These policies are the surest way to reduce stigma against people who use drugs and are the most promising solutions for ending the current emergency and preventing future similar emergencies.

VCH has operated an overdose surveillance system that integrates overdose information from VCH urban emergency departments and Insite for many years. Over the course of the emergency the system has been

expended to capture information on overdoses presenting to VCH rural hospitals, BC Children's Hospital, the Mobile Medical Unit during its deployment in the Downtown Eastside, the Dr. Peter Centre and all the Overdose Prevention Sites. The system has also been used to identify the degree to which patients presenting with overdose are connected to VCH health services.

A leading practice in this area has been to develop information sharing agreements with partner agencies such as the BC Coroner's Service and BC Emergency Health Services to obtain additional detailed information related to overdoses that is not held by public health authorities allowing us to better characterize the affected population and develop more targeted services.

Alberta Health Services

Alberta Opioid Surveillance Dashboard

Overview of the practice: Provides province-wide surveillance information to users in AHS for program planning, data informed decision-making, and public communication.

How practice was developed and implemented: The Province-wide Surveillance Dashboard has utilized existing data in AHS (from EMS, EDs, Healthlink, etc.) into an easy visual format using Tableau. The dashboard accounts for opioid related-deaths, HealthLink calls, ED visits, hospitalizations, and EMS responses.

Initial results/next steps: Data in the dashboard are updated daily, weekly, and monthly. A publicly available version for sharing surveillance information with partners outside AHS is being developed.

Safe Opioid prescribing standards/guidelines

Overview of the practice: In Calgary Zone, a multi-stakeholder working group has developed a dashboard to track all opioids prescribed in both an inpatient and an outpatient setting.

How practice was developed and implemented: Data from this dashboard have been presented to numerous physician groups in acute care and the community. An automatic alert is being developed for all Calgary acute care sites that will flag opioid-naïve patients where an opioid is prescribed at a dose of >200mg morphine equivalents (OME).

Initial results/next steps: The result of this initiative has been a steady decrease in the prescription of opioids >100 mg OME by Calgary physicians since 2013. Also, now several clinical groups are focusing on improving the safety of opioid prescribing.

Winnipeg Regional Health Authority

Addictions Unit has been working to develop a Consult Team Service focused on supporting those areas with particular challenges in overdose or with patients entering the health care system with an ongoing addiction - Womens Health, Emergency and Medicine - the consults would provide understanding for Clinicians and the Patients for access to clean kits, provision of naloxone and access to community resources.

Enhancing community knowledge: attending public forums, holding conferences on overdose, public training on fentanyl, overdose prevention, recognition and response, lecture to Med II on prescribing and opioid dependence/overdose/naloxone.

Hamilton Health Sciences

Proposed review of HHS order sets (physician de-prescribing) containing opioids to assess opportunities to improve safe opioid prescribing is being undertaken. A presentation to the Medical Advisory Committee on April 12, 2017 by Pharmacy & Therapeutics Committee members and a presentation on June 14, 2017 to physician leaders on utilization issues is planned.

The Ontario Narcotics Monitoring System (NMS) was implemented in 2010 through the Narcotics Safety and Awareness Act. It was intended to reduce prescriptions for opioids and controlled substances that were highly likely to represent misuse. Access to the Ontario Narcotics Monitoring System is now available through Clinical Connect providing clinicians with a tool for enhanced monitoring of opioid use.

The concept of Opioid Stewardship has been approved by the Medical Advisory Committee based on the following recommendation from the Pharmacy & Therapeutics Committee:

“The Pharmacy and Therapeutics Committee recommends to the Medical Advisory Committee the development and implementation of a broad assessment and evaluation plan of the prescribing practices of opioids by practitioners at HHSC in line with the comprehensive provincial and federal opioid strategies to tackle opioid addiction and overdose”.

Sick Kids Hospital

The emergency department has a number of policies in place to help in the management of opioids for use in the treatment of chronic pain. These are Policies include:

1. Management of Acute Sickle Cell Crisis/Chest Crisis
2. Management of Acute Appendicitis
3. Management of Acute Supracondylar Fracture
4. Management of accidental/intentional opioid overdose in children and teens

These policies are aimed at safe prescribing in the acute setting of their condition and by extension they also focus on out-of-hospital care of chronic pain, for example, by prescribing alternative medications.

St. Michael's Hospital

Often, the prevention of addiction and overdose begins in the ED or general medical wards. Our institution has found that strictly enforced elements aimed at limiting opiate prescribing often only serve to under-treat the pain of patients with addiction, increasing risk of leaving hospital against medical advice at a time of clinical instability and increased risk of overdose. Instead, we have been building capacity amongst staff for better screening and case finding. Identified patients still receive appropriate pain management and do not lose opiate tolerance but are closely followed in hospital and offered follow-up regarding opiate prescribing after discharge from hospital. As well, physicians (either in-patient or out-patient) with patients on morphine equivalents greater than 200mg or unclear indications for opiate prescribing are asked to refer for an addiction assessment.

We also work to manage pain cases in consultation for which opioid dosing has become high risk. For people presenting for surgery who have substance use disorder or regular opioids prescribed, the patient is seen pre-operatively, perioperatively, and during the transition to the community. The patient receives an assessment for

both the addiction and pain as well as optimal treatment for both disorders. When there is chronic non-cancer pain and chronic opioid use, we work with individuals closely to transition to safer medications. Evidence is starting to suggest that buprenorphine may be safer and better for pain for some patients with chronic non-cancer pain on high morphine equivalents.

UHN

A. The impact of an upstream shared-care interprofessional model of care for low-back pain to minimize chronic opioid use for low back conditions. Y.R. Rampersaud MD, FRCSC

Background: Low back pain (LBP) is among the most frequent reasons for primary care physician visits, and is a leading cause of years lived with disability. Despite significant evidence of limited to no benefit of opioid use in this population, in the US up to 41% of patients receive an opioid prescription within one year of a LBP diagnosis.

Intervention: The Inter-Professional Spine Assessment and Education Clinic (ISAEC, www.ISAEC.org) was established in Ontario (pilot sites in Toronto, Hamilton, and Thunder Bay) in November 2012 with funding from the Ontario Ministry of Health and Long-Term Care. ISAEC's purpose is to enable shared care management of LBP by employing a network structure between primary care providers (PCPs: medical doctors and nurse practitioners), advanced practice clinicians (APCs, specially trained physiotherapists and chiropractors) and specialists (surgical, pain, and rheumatology) to deliver timely access to evidence-based LBP assessment and risk stratification, care recommendations, education, and support to enable patient self-management of LBP.

Outcome: In a review of 4746 patients, more than half were at moderate to high risk of having chronic persistent LBP. At first visit, 20% of patients reported using at least one opioid medication, with nearly 1 in 5 of these individuals characterized as being at moderate or high risk of opioid abuse compared to 1 in 8 of those not using opioids. In a sub-group of patients enrolled in a longitudinal study, 18% of opioid users at initial ISAEC assessment were not using them 6 months after participating in the ISAEC program. Independent predictors of ongoing opioid use at 6 months included smoking, previous history of LBP, and high pain-related disability at initial visit.

Key Point: Upstream shared-care interprofessional management provides an ideal setting to reduce downstream escalation of opioid dependency in LBP.

B. Increasing the health provider role in education and facilitating the safe storage and disposal of prescription opioids. Y.R. Rampersaud MD, FRCSC

Background: Children most often obtain prescription opioid drugs from their own home, or that of a friend. Unused prescription opioids are often left in the home following orthopaedic surgery or acute orthopaedic injury (e.g. fracture). Given that a substantial proportion of the orthopaedic patient population receives opioid prescriptions, there exists an opportunity to effect safer opioid storage, and disposal by targeting this group directly.

In an ongoing needs survey undertaken in our ambulatory Orthopaedic/Fracture clinics (University Health Network, Toronto Western Hospital; approximately 25K visits annually), the following preliminary key points were found:

1. 70% of patients have been prescribed an opioid at some point – 20% are current users;
2. 40% of these patients report having unused opioids at home;

3. only 25% of these patients reported receiving opioid storage information from a pharmacist and 16% from a clinical healthcare provider (23% did not recall);
4. only 29% reported receiving disposal information from a pharmacist and 13% from a clinical healthcare provider (10% did not recall);
5. 77% of patients would be willing to bring their unused opioids to their next clinic appointment for disposal.

Intervention: Orthopaedic Opioid Safety Project (Pilot project currently in development and planning phase). The objective of this pilot project is to assess the impact of an education program aimed at enabling our orthopaedic surgeons, trainees, frontline clinical staff (e.g. nurses and technicians) and clerical staff to promote safe use, storage, and disposal of prescription opioids among our patients, including facilitating the return of unused opioids to our institution's on-site outpatient pharmacy as part of routine clinical care. Success in this pilot will enable expansion to all surgical divisions within our institution.

Vitalité Health New Brunswick

Interdepartmental Illicit Fentanyl Preparedness Task Group (IIFPTG)

The Department of Health (DH) established the Interdepartmental Illicit Fentanyl Preparedness Task Group (IIFPTG) in February 2017 with a six month mandate to oversee the development and implementation of plans and other measures to prevent and respond to illicit fentanyl overdoses in New Brunswick, and to keep informed on best practices and emerging issues.

Key goals and strategies are to promote prevention, awareness and intervention strategies as it relates to fentanyl misuse and overdose and to identify, build and strengthen community partnerships.

The Task Group is chaired by the Director, Emergency Preparedness and Response and includes members of the DH, RCMP, Horizon and Vitalité Health Networks, AmbulanceNB, Justice and Public Safety, Health Canada (First Nations Inuit Health Branch), and First Nations.

In accordance with the Task Group's terms of reference and stated objectives, five sub-task groups were established:

- **Public Communications:** Develop targeted public awareness / communications strategy for populations at risk for fentanyl overdose (recreational drug users, illicit opioid users) on how to prevent, identify and respond to fentanyl overdoses.
- **Resources / Education:** Develop guidelines and associated educational materials and assessment tools for first responders, public educational institutions, and parents / family members relating to fentanyl overdose identification / recognition and response.
- **Personal Protective Equipment / Occupational Health and Safety:** Develop fentanyl safe handling and personal protective equipment guidelines for first responders and first receivers.
- **Surveillance:** Develop and implement a surveillance and reporting structure and system involving the timely collection, analysis, interpretation and reporting of opioid overdose data from appropriate sources to inform action and decision-making.

- **Treatment Interventions:** Conduct a review of existing addiction and mental health services in NB as it relates to opioid use and dependence, make recommendations to ensure programs and services are aligned with best practices and enhance awareness of treatment options for opioid use disorder.

Innovative Practices in New Brunswick

An innovative practice in New Brunswick has been undertaken by the Horizon Health Network. Public Health in Cumberland County has assembled a multi partner stakeholder working group that includes Addiction and Mental Health, local Police Forces, three First Nations Communities and others to address issues related to the risk of opioid and fentanyl use. Issues being addressed include public education, the development of Needle Exchange Programs and the distribution of Naloxone Kits.

IWK Health Centre

Pediatric Pain Management Program

The Pediatric Pain Management Program works in collaboration with pediatricians, surgeons, and family doctors to manage children's pain after surgery or injury, and pain caused by cancer, infections, arthritis, or other illnesses. They also help children with complex or chronic pain. They use a multidisciplinary team approach to control pain with both medication and non-drug techniques. The team provides care for inpatients (Acute Pain Service) as well as outpatients (Complex Pain Clinic). They are available to help any child in the Maritime Provinces whose pain is not adequately controlled.

Children who are patients in hospital are seen by the consultation team at the request of the primary pediatrician or surgeon. The program can provide a range of pain treatment techniques, including medications by mouth or intravenous infusion, epidural or nerve block, and patient-controlled analgesia. They also assist with pain assessment in children who have difficulty expressing or explaining their own feelings.

The Pediatric Complex Pain Clinic treats outpatients with chronic pain. Assessments and treatment are provided by a team including a physician, a clinical nurse specialist, a clinical psychologist, and a physiotherapist. Treatment often includes a combination of physical treatment and exercise, cognitive-behavioural techniques such as relaxation and imagery, and medications. The child and family are important members of the pain management team.

Opioids are used rarely, and generally only when there is clear evidence of improved function, not just a sensation of comfort or reduced pain intensity. There is, however, no question that some patients with chronic pain (adult or child) will benefit tremendously from well-managed opioid therapy in combination with other treatments.

IWK Regional Poison Centre

The IWK Regional Poison Centre has been working with Health Canada as well as the Provincial Public Health Department to look at the data gathered by the Canadian Poison Centres to help inform the issues related to the opioid crisis.

The Poison Centre is part of a provincial opioid harms committee established last fall to address the anticipated opioid crisis in Nova Scotia. Dr. Robert Strang, Chief Medical Officer of Health for the province, has brought together health care (medical examiner, poison centre, addiction specialists) law enforcement, epidemiologists, and public health officials to tackle every angle. The poison centre's Medical Director Dr. Nancy Murphy serves

on the surveillance subgroup with the medical examiner's office, and the poison centre provides a monthly report on poison centre calls for opioids which is part of a full report containing medical examiner/law enforcement/addictions data.

The poison centre also provides information on the role of the Antidote Program in optimizing emergency preparedness with naloxone stocking that would save lives in the event of a "mini-epidemic" anywhere in the province. The centre has provided the number of naloxone vials contained at each ED in the province to show the readiness of different facilities.

The IWK Regional Poison Centre has also been working with the Director of Emergency Health Services (EHS) to develop a minimal data set and a policy for reporting all suspected opioid overdoses to the Poison Centre.

Eastern Health

Implementation of Provincial Pharmacy Network: Efforts continue to have all pharmacies connected to one provincial pharmacy network by the end of May, 2017.

Public Awareness/education campaign: A multi-faceted campaign focused on opioid overdose awareness and naloxone was launched the week of May 29th. This campaign, which consists of posters, social media advertising, movie theatre advertising and wallet cards, will run for approximately 6 weeks.

City of St. John's Fentanyl Action Group: The City of St. John's, Eastern Health, the Department of Health & Community Services and a number of community based organizations partnered to develop a response to the growing concerns related to fentanyl use in the capital city. As part of this plan, this group announced its intentions to establish pop up sites at various city parks and festivals over the coming months. These pop up sites would enable the public to learn more about fentanyl and other opioids and to provide take home naloxone kits to those who may require it.

Surveillance: A Surveillance Working Group has been formed to collect, analyze and interpret qualitative and quantitative information regarding opioid overdoses and emerging issues related to opioids in NL. In April, 2017, Eastern Health issued a public advisory about an increase in the number of serious overdoses related to an opioid being sold as heroin in the St. John's metro area. Over a two- week period, Eastern Health became aware of approximately 15 reported overdoses, including at least one death.

Eastern Health Task Force: Eastern Health recently established an internal task force for the purpose of communicating and coordinating efforts taking place within the health authority. The membership is comprised of a cross representation of senior leaders across the organization and its focus will be on surveillance, education/awareness (staff and public), take home naloxone program and treatment.

Safe Prescribing Course: A mandatory Safe Prescribing course was announced in March 2017. This course was developed in partnership with the College of Physicians & Surgeons of NL and Memorial University's Faculty of Medicine. The course focuses on safe/appropriate prescribing practices for opioids, stimulants and benzodiazepines and is mandatory for all new physicians but open to other prescribers and health professionals.

Community Grants Program: This grant program is intended to support community organizations in their efforts to prevent substance use related problems and promote mental wellness. Eastern Health offers consultation and support to the recipients of these grants in the planning and implementation of their projects.

Canadian Centre on Substance Use and Addiction:

Our vision at the Canadian Centre on Substance Use and Addiction (CCSA) is of a healthier Canadian society where evidence transforms approaches to substance use. As the only national organization supported by an Act of Parliament to address substance use in Canada, our mandate is to ensure this issue remains on the national agenda for action not only in a short-term crisis, but also in the long term.

Regarding the Joint Statement of Action to Address the Opioid Crisis in Canada

CCSA strengthened collaborative efforts by partnering with Health Canada to plan and stage the national Opioid Conference and Summit. Building on the work and collective efforts of the national First Do No Harm strategy, and on behalf of the federal Minister of Health, CCSA is committed to maintaining its role as convener and connector.

Activities Completed by CCSA as Part of the National Opioid Response

Joint Statement of Action to Address the Opioid Crisis in Canada

- Demonstrated leadership in strengthening collaborative efforts by partnering with Health Canada to plan and stage the national Opioid Conference and Summit. Increased signatories and commitments made to the Joint Statement of Action and ensured collaborative responses.
- Developed tool related to the opioid guidelines for physicians with seven national medical organizations (e.g., CMA, CFPC, FMRAC, CMPA).

First Do No Harm: Responding to Canada's Prescription Drug Crisis

- Led the development of the First Do No Harm strategy (2013) with over 40 partners to address the challenges of prescription drugs and provide a roadmap for action. This work led to key initiatives with partners that included the new prescribing guideline; core competencies for health professionals related to addiction and pain; a report on core components of effective prescription monitoring programs; a study of the perceptions about prescription drugs of 1,200 health professionals in Alberta; and the sharing of best practices and resources.

National Picture and Data Trends

- Published bulletins and alerts through the Canadian Community Epidemiology Network on Drug Use that reach over 1,400 subscribers. Topics included fentanyl deaths since 2009–2014, a summary of availability of naloxone by jurisdiction, 911 call and barriers and a costing tool to promote greater availability of naloxone in the provinces.
- Collaborated with the Canadian Institute for Health Information in 2016 to produce a report on “Hospitalizations and Emergency Department Visits due to Opioid Poisoning in Canada.”

Care Pathways for Youth and Older Adults related to Opioid Use Disorder

- Developed (2016–2017) two sets of evidence-informed opioid-related care pathways (one for older adults and one for youth) to improve and ensure quality of care response for individuals who are experiencing opioid-related harms.

Community-based Opioid Agonist Treatment Programs in First Nation Communities

- Partnered with the Assembly of First Nations Mental Wellness Committee and Thunderbird Partnership Foundation to expand access to community-based opioid agonist treatment programs that include counselling, traditional healing, cultural supports and substitution therapy. A guidance document for use in First Nation communities is being finalized.

Improving the Quality of Treatment Services in Community Residential Facilities

- Collaborated with the Canadian Executive Council on Addictions and all accreditation bodies in Canada to enhance the quality of treatment services through accreditation. There are about 400 publicly funded community residential treatment facilities not associated with hospitals or regional health authorities and one third of those facilities are not accredited.
- Examined the regulatory frameworks in three provinces that could be used to provide oversight of currently unregulated and unlicensed privately funded community residential treatment facilities
- Drafted a consumer beware manual that describes the private and public landscape of community addiction treatment services to inform individuals and families about the addiction treatment system, and to help them make informed choices about treatment and service options. Currently in consultation with family, parent and consumer groups across Canada.

Joint Statement of Action: Public Reporting, Monitoring and Community Building

CCSA is working with those organizations that signed commitments in the Joint Statement of Action to ensure a true collaboration between the many different organizations and perspectives involved. For accountability and transparency, actions related to the commitments signed in the Joint Statement of Action were publicly released on May 31, 2017, in partnership with Health Canada and the office of the federal Minister of Health.

CCSA is continuing to increase the number of commitments from the organizations that signed at the Summit, and is working with new organizations and partners to submit new commitments to address gaps in the Joint Statement of Action related to treatment, harm reduction and enforcement.

This work has produced a clear picture of current efforts, capturing the variety of initiatives being deployed to address the crisis, as well as the many players involved. This work has allowed the community tasked with addressing the opioid crisis to expand and fortify a network of specialists in the field. We are seeing partnerships and relationships develop between groups that would not otherwise have collaborated on initiatives. For example, there is one coalition currently focused on recommendations for alternative pain management.

Care Pathways Assessment

CCSA is assessing the effectiveness of two care pathways developed to improve treatment for youth and older adults who are experiencing issues related to opioids and other psychoactive prescription drugs. These pathways help primary care providers offer better, more effective support to those who might be experiencing prescription drug misuse, with a view to responding in a more timely and effective way. We will work closely with jurisdictions – the ultimate users of the care pathways – to ensure that the newly developed care pathways are relevant and appropriate in all contexts.

Canadian Community Epidemiology Network on Drug Use

The Canadian Community Epidemiology Network on Drug Use (CCENDU), an early-warning network led by CCSA, bridges the gap between frontline experience and evidence through the timely production and dissemination of bulletins and alerts about drug-related health threats and potential actions to prevent and reduce harms. CCSA and network partners from across Canada share these alerts and bulletins broadly among intermediary organizations, both nationally and internationally, that represent treatment providers, law enforcement, first responders, healthcare practitioners and those who use drugs. In total, there are 1,453 individuals and organizations registered to receive CCENDU alerts and bulletins. Feedback from subscribers has shown that they implement this information quickly into their clinical practice. For example, CCSA published a brief on fentanyl in 2015, before the issue had been widely recognized. CCENDU partners promoted it through their networks, resulting in lives saved because first responders recognized what they were dealing with.

Workforce

CCSA has produced resources for the substance use and addiction workforce in response to requests from service providers for effective evidence-informed approaches and responses to help inform their work with clients and patients. Facilitated by CCSA, Canadian experts write these resources, which offer clear overviews, and the key principles and components of each topic, along with a list of selected resources.

APPENDIX 3: LEADING PRACTICES - TREATMENT

British Columbia Centre on Substance Use (BCCSU)

The BC Centre on Substance Use (BCCSU) is a newly-formed provincial centre in British Columbia with the mandate to develop, to help implement, and to evaluate evidence-based approaches to substance use and addiction.

Leading practices being employed at the BC Centre on Substance Use that are relevant to other jurisdictions grappling with challenges related to opioid use and addiction include:

- The establishment of dedicated fellowship training programs for physicians and nurse practitioners in the area of addiction medicine (noting that a great deal of emphasis is being placed on the role of primary care physicians and moving away from specialist-led models, given the prevalence of opioid addiction);
- The provision of a new Guideline for the Clinical Management of Opioid Use Disorder, published by the BCCSU in conjunction with the BC Ministry of Health (MoH), which is scheduled to be adopted as the new provincial guideline as of June 2017 to provide guidance for the full continuum of evidence-based opioid addiction treatment and care;³
- The development of a guidance document for injectable opioid agonist therapy (iOAT) with the goal of expanding the availability of hydromorphone and diacetylmorphine for that small proportion of the population with very severe opioid addiction that has traditionally been extremely difficult to treat with oral agonist therapies; and
- The expansion of peer group involvement in both the treatment and recovery aspects of addiction treatment and care. The BCCSU views it as a leading-edge practice to more fully engage people who use drugs, their family members, and individuals in recovery, in assisting with the response to opioid addiction. Indeed, we believe that peer groups should be involved at every step of the process, and we note that, while peers have been involved in the harm-reduction continuum in many jurisdictions, they have not been adequately involved in the addiction treatment sphere. We recommend that their input be more actively solicited in response to the present opioid-related public health emergency.

British Columbia Mental Health and Substance Use Services

BC Mental health & Substance Use Services (BCMHSUS) provides tertiary and quaternary inpatient and community based assessment and treatment services for those with mental health and substance use disorders.

Treatment of addictions:

- BCMHSUS provides a continuum of hospital and community based tertiary and quaternary level treatment, trauma informed, and recovery based rehabilitation services for this complex, concurrent disorder population.
- Evidence -based therapeutic interventions include:
 - Matrix program – evidence based intervention for substance use disorders

- Seeking Safety – focus on psychological trauma as driving dynamic in substance use disorders, esp opioid
- Illness management and Recovery (IMR) - for mental illness and substance use
- START Now – trauma informed, recovery based program to address antisocial attitudes and behaviours
- Interdisciplinary diagnostic, risk, and treatment needs assessments, and development of Integrated Treatment Plans
- Self-help groups – AA, NA,
- Chronic health conditions assessment, treatment by Family Practitioner, Nurse Practitioner, as integral members of treatment team.
- Dedicated psychologically based treatment staff (psychologists, program therapists)

First Nations Health Authority

The First Nations Health Authority (FNHA) has proactively accelerated actions to prevent, address and/or mitigate the impacts of overdoses and deaths related to the opioid crisis among First Nations. However, the issues of substance use are longstanding and connected with intergenerational trauma and colonization. FNHA recognizes the need for a long-term, cross-sectoral and partnered response consistent with cultural safety and humility, upstream interventions and trauma-informed care.

Practice: Cultural Safety and Humility Initiatives

FNHA works with system partners to advance cultural safety and humility, and trauma-informed care for First Nations and Indigenous peoples in the BC health system.

Development/Implementation: First Nations continue to be impacted by colonization and oppression, both at the individual and system level. First Nations experience stigma, racism, and discrimination in their health care interactions. Access to respectful health care is an important determinant of health and wellness for First Nations.

FNHA has been working to ensure inclusion of cultural safety and humility and trauma-informed care in all opioid crisis response activities, as well as in the BC Ministry of Health’s cross-government mental health and substance use strategy, design of mental health specialized care programs, and primary and community care transformation. FNHA has also committed to mandatory trauma-informed care training and cultural safety training for its staff and has offered trauma-training for frontline staff in community.

Initial Results:

- There is strong momentum on cultural safety and humility across the entire BC health system with the Ministry of Health, Health Authorities, 23 Health Regulators, and the BC Coroners Service. These organizations have signed Declarations of Commitment to develop and report on strategic activities to advance cultural safety and humility.
- FNHA’s advances its Cultural Safety and Humility Policy Statement, awareness campaign, tools and resources, and training initiatives. www.fnha.ca/wellness/cultural-humility

Fraser Health Authority

Supervised Consumption Services (SCS) and Opioid Agonist Treatment (OAT) integration: Findings from the scientific evaluation of supervised injection services at Insite in Vancouver demonstrate that among people who use drugs, those attending Insite have a significantly increased likelihood of engaging in treatment for substance use. In order to take greatest advantage of this benefit of supervised consumption services, Fraser Health has designed its first two SCS to have OAT immediately available to those who wish to initiate treatment and are eligible. At SafePoint (135A Street, Surrey) rapid access OAT has been implemented at the adjacent SHOP clinic. At Quibble Creek Sobering and Assessment Centre, where SCS is being implemented as part of standard practice, rapid access OAT has been implemented at the substance use clinic in the same building. Referral and uptake of this unique arrangement of services, strengthening the continuum of care, will be evaluated.

Emergency Department Initiated Buprenorphine/Naloxone: In this program, patients arriving to the ED with opioid use disorder have the option of being inducted on buprenorphine/naloxone then referred to an outpatient opioid agonist treatment clinic for stabilization. This is particularly useful for patients who are admitted with an overdose. They can be observed in the ED until withdrawal sets in then started on buprenorphine/naloxone.

Opioid “Detoxification” Waiver: As current evidence shows that opioid detoxification without continued addiction treatment results in relapse in 80–90% of clients and increase the chance of overdose, the Fraser Health Detox centers use a waiver advising these risks to the client and recommend opioid agonist treatment as the evidence based treatment.

Island Health

Concrete actions around treatment interventions:

- Added 42 net new supportive recovery treatment beds added across Vancouver Island, including five stabilization beds to support post-detox care.
- Enhanced connectivity, linkages and referrals within mental health and substance use service continuum.
- Increased education to service providers, Emergency Department physicians/staff and Opioid Agonist Therapy (OAT) clinics on the evidence and effectiveness of OAT.
- Increased public and stakeholder awareness around where and how OAT services can be accessed.
- Opened a Rapid Access Addiction Clinic in Victoria to increase capacity and provide timely access for clients seeking OAT or methadone treatment. This service also links to other community services and ensures smooth transitions for clients as they transition through recovery and treatment programs.
- Integrated with Central Access and Rapid Engagement Services (CARES) and Sobering and Assessment Centre for rapid access to Mental Health and Substance Use programs, including specialist consultation and harm reduction supplies.
- Developed ‘Connections’ information and support drop-in group for individuals in Victoria seeking information about addictions or waiting for service.

- Increased support for community GPs to expand their capacity to care for patients with mental health and substance use conditions within their practices through education, embedded mental health and substance use clinicians ('health consultants'), phone lines for specialist consultation, etc.
- The Victoria Youth Clinic in coordination with Discovery and Youth Detox has developed a Rapid Access Clinic for youth. Dr. Ramm Herring has also been involved in Opening Rapid Addiction Access Clinics in Coordination with Emergency Departments on the Island.

Providence Health Care

Crosstown Clinic: Supervised injectable opioid agonist treatment with either hydromorphone or diacetylmorphine is safe effective and cost saving when provided to opioid users who continue to inject illicit opioids despite attempts at the standard oral treatments. Crosstown Clinic was the first clinic in Canada to offer this treatment and is still the only clinic providing prescription heroin. For a small number of people this is the only treatment that will attract them into care.

The clinic has retained in care some of the country's most vulnerable people and seen some remarkable transformations. They believe the key is the supervised model which allows building relationships. Daily attendance at the clinic and regular contact with health providers has led to marked health improvements.

The major challenge has been stigma. Health Canada and Minister Philpott have assisted greatly in breaking down some of the discriminatory bias against people who use drugs simply by supporting supervised consumption sites and the use of supervised injectable opioid agonist treatment, and prescription heroin. Continued support will lead to expansion beyond Crosstown. Support from politicians, police, and the judiciary has preceded acceptance by health providers for injectable treatment options, at least in Vancouver.

Vancouver Coastal Health

DTES Connections Clinic: In March 2017, VCH opened a new low barrier, low threshold opioid replacement clinic. The Downtown Connections Clinic (Connections) aims at increasing the uptake of OAT and at transitioning clients to established primary care services after a stabilization period. Since opening Connections, 250 patients started OAT and the target of initiating therapy within 120 min from registration has been met. Retention is currently being monitored, and a proactive system of care is being implemented to prevent clients from becoming lost to care. In addition, 50 post-OD clients from ambulance services were accepted to Connections, thus ER visits were averted

Increase Capacity for OAT in the Community: VCH, through the Department of Family and Community Practice, has partnered with the newly created BC Centre on Substance Use (BCCSU) to provide opportunities for physicians across VCH. These opportunities include workshops (22 MD and 7 NPs have attended) and a two-week preceptorship training program (6 MDs already enrolled) to improve knowledge, skills, and capacity to prescribe methadone and Suboxone®.

Quality Improvement Collaborative and Health System Redesign: VCH, in partnership with the BC-CfE, is launching a structured learning collaborative that builds from lessons learned from similar HIV/AIDS intervention. This intervention will focus on the continuum of care for people with opioid use disorder, increasing the uptake of OAT, engagement and retention of about 4,000 patients. Twenty-four primary care and addictions teams across Vancouver will come together and use CQI methodology to improve outcomes for people with opioid substance use disorders. It is expected that gaps in care (undiagnosed cases, late initiation

of OAT, poor retention in care, etc.) will be addressed using this methodology. Health system redesign will result in patient-centred, integrated, coordinated and proactive care.

Vancouver Coastal Health has been increasing capacity to provide addiction treatment for opioid use disorder, particularly scaling up specialized low-threshold or “treatment on demand” services such as the St. Paul’s Hospital Rapid Access Addiction Clinic and the DTES Connections Clinic. We are supporting these services with community outreach to help patients navigate the system and remain connected to care. We have also been discouraging the use of abstinence-based treatments such as withdrawal management for patients with opioid use disorder as such services are known to increase mortality due to loss of tolerance and extremely high rates of relapse.

VCH is also creating an Opioid Agonist Therapy Provider network to increase community and primary care OAT capacity and improve flow of patients from specialized addiction services into community and primary care settings.

A leading practice in this area is the provision of injectable opioid agonist therapy (iOAT). This evidence-based treatment is provided within our region to a limited number of clients and although we have plans to expand access considerable cost and legal barriers remain. Hospital pharmacies have been identified as potential sites able to provide this therapy with minimal barriers.

Alberta Health Services

Opioid Dependency Treatment (ODT) Providers’ Network

Overview of the practice: Facilitates mentoring, consultation, and educational opportunities between opioid dependency treatment (ODT) experts and those with little experience. The Network has several components that aim to better support practicing ODT physicians as well as physicians new to ODT.

How practice was developed and implemented: The ODT Providers’ Network was created in collaboration with front-line ODT physicians and allied health providers across the province. The On-Call Consult service will utilize the new eConsult and eReferral platforms that the Alberta Netcare team has created. The ODT e-Preceptorship service meets the preceptorship requirement for methadone exemption.

Initial results/next steps: Two experienced physicians identified, the on-call portion is planned to be available in the summer of 2017 and the mentoring in the fall of 2017. Collaboration is underway to develop ePreceptorship program.

Integration of Opioid Dependency Treatment (ODT) in Primary Health Care

Overview of the practice: Distinct partnerships (two) have been established bringing together primary care clinics, including family physicians and their teams, with specialty opioid dependency treatment (ODT) programs and experts to support and identify opportunities for the delivery ODT in primary care.

How practice was developed and implemented: This provincial innovation in practice, was driven by the partners involved, and grew out of the Advisory Committee for the Integration of ODT in PHC. Beginning as a proof of concept, there is intent to build toward model that can be used throughout Alberta. This work will occur in partnership with key stakeholders within Alberta’s government, AHS, Alberta College of Family Physicians (ACFP) and others building on strategic priorities identified during the Opioid Crisis Response Planning Summit: Opioid Management in Primary Care hosted by ACFP and Alberta Health.

Initial results/next steps: Leverage lessons learned to enhance opportunities for and uptake of models for integration of ODT within primary care clinics, increasing the availability of ODT for Albertans in their home communities. Further align actions with the strategic priorities identified from the Planning summit. Build on established relationships and resources to explore development of health service pathways in ODT and pain management

Novel Treatment Expansions

Overview of the practice: AHS has opened four opioid dependency treatment (ODT) clinics since 2015, three of which have novel designs not tried before in Alberta.

How practice was developed and implemented: The novel designs utilize technology to improve access of ODT in rural areas, partners AHS and private ODT physicians, and establishes satellite support clinics to decrease the burden on the specialty clinics.

Initial results/next steps: All three models are now open. Initial response has been positive. Next step is to support the development of a hub and spoke model that spreads urban services to suburban locations.

Initiating Opioid Dependency Treatment (ODT) in locations that are not specialty clinics

Overview of the practice: Due to a high volume of opioid dependent patients in hospitals, detox facilities, and Correctional facilities and their high risk of overdose will allow for Suboxone initiations to take place at several sites.

How practice was developed and implemented: Inpatient centres where patients are withdrawing from opioids are ideal places to initiate Suboxone as this addresses one of the common barriers to starting opioid dependency treatment (ODT). Initiated patients are referred to an ODT clinic for stabilizing, maintenance, and psychosocial support.

Initial results/next steps: A pilot in one correctional facility. Several detox facilities are increasing their capacity for initiations. More Emergency Departments will be recruited, creating more referral channels to ODT clinics for continuity of care.

Psychosocial Support to Private Opioid Dependency Treatment (ODT) Clinics

Overview of the practice: Private opioid dependency treatment (ODT) clinics are unable to hire psychosocial supports due to funding limitations, and this is a crucial piece for recovery.

How practice was developed and implemented: Utilizing new relationships with private ODT clinics, part-time Addiction Counselor or Social Worker support has been provided to each clinic.

Initial results/next steps: AHS has provided this support to 8 private ODT clinics. As new clinics are being opened, new support is being offered as funding allows.

Sioux Lookout First Nations Health Authority

The Sioux Lookout First Nations Health Authority (SLFNHA) represents and serves over 30 First Nations communities in Northwestern Ontario, the majority of which are remote, fly-in communities spread over a vast geographical area (385 000 km²). These communities declared states of emergency in 2009-12 re: epidemic levels of opioid dependence (Oxycodone, at that time) with corresponding devastating social and medical

impacts of opioid misuse. These First Nations communities developed community-based treatment programs in partnership with community physicians with support from SLFNHA's Regional Wellness Program and visiting addictions specialists. Programs providing opioid substitution therapy with buprenorphine-naloxone (Suboxone) and psychosocial supports including land-based and cultural activities now exist in over twenty communities, with over 1400 participants (up to 41% of adults in some communities are receiving treatment). Local guidelines for the establishment and support of these programs have been published. In most cases, induction and stabilization on OST take place in-community under the supervision of visiting physicians, then ongoing DOT is provided by community addictions workers. This is accompanied by community-driven culturally-appropriate programming, particularly as part of an intensive induction month.

Outcomes: Most community programs began in 2012-13, allowing for several years of social and clinical experience of the enormous impact of these programs on individuals and communities, and the publication of nearly twenty research articles. Some highlights:

- After program introduction in one community, criminal charges and child protection cases dropped by 61.1% and 58.3% respectively, while school attendance increased by 33.3% and uptake of seasonal influenza immunization (as a marker of engagement in medical care) increased by 350%. Participants and communities also describe subjective improvements in community well-being.
- Retention rates in treatment far higher than reported in most OST programs (84%, 78%, and 72% at 6, 12, and 18 months respectively) despite a patient population with very high underlying rates of post-traumatic stress disorder and intergenerational trauma.³
- Significant improvement in glycemic control (1.2% drop in HgbA1c) in patients with coexisting opioid use disorders and type 2 diabetes.⁴
- Buprenorphine-naloxone appears to be safe for use in pregnancy, and Buprenorphine has a superior NAS profile than methadone. ^{5,6}

Summary: Five years of experience has showed that opioid substitution therapy with Buprenorphine-Naloxone (both induction and ongoing maintenance) in remote, primary care settings shows this is safe and effective. The partnerships between medical staff, community workers, and community leadership have been crucial to this success. We strongly encourage governments, policy makers, and colleagues across Canada to expand access to and the use of Buprenorphine-Naloxone to allow for the appropriate treatment of opioid use disorders to be integrated in primary care settings.

Hamilton Health Sciences

Prescribing Order Sets

An opioid withdrawal order set has been developed by Emergency Department clinicians and discussed at the Pharmacy & Therapeutics Committee for admitted patient use. Physicians are reporting anecdotally inpatients admitted for other disease management who would qualify for opioid withdrawal management.

Opioid Use Disorder

As published in the Government of Canada Gazette Vol 151, No 16 April 22, 2017, the federal government is proposing regulations amending the Food and Drug Regulations for the expedited importation of drugs for treatment of Opioid Use Disorder available in other countries (examples are buprenorphine/naloxone sublingual film and naloxone nasal spray). Currently there is no regulatory mechanism available in Canada to

address an urgent public health need through a population-based approach. The Ontario Hospital Association has reached out to its member hospital Directors of Pharmacy for feedback on the proposed regulation. The Chief Medical Officer of Health of Ontario would be the individual responsible for defining the list of drugs to be imported under this regulation. The primary issue identified by the Directors of Pharmacy related to a communication plan to appropriate stakeholders. The proposed regulations have been discussed at the Pharmacy and Therapeutics Committee May 2017 meeting.

Sick Kids Hospital

Adolescent Substance Abuse program:

Treatment provided by this program is not specifically focussed on opiate use disorders, however there are patients who have and are using opiates.

The [Substance Abuse Program](#) provides Day Treatment Services and Outpatient Services. Through both services the program provides:

- Assessment and treatment for teens up to 18 years of age.
- A parent program and support for families or guardians of teens in the program - upcoming parent group dates will be announced soon
- Comprehensive health assessment and medical follow-up as needed.
- Education about adolescent alcohol and substance use and abuse.

Substance Abuse Day Treatment Program

- The program hours are Monday to Friday; from 9 a.m. to 3 p.m.
- There is a maximum of 8 to 10 teens in the program.
- Individual treatment is aimed at reducing or eliminating substance use in accordance with the program's harm reduction philosophy.
- An academic program is available with opportunities for the teens to work towards secondary school credits with the Toronto District Secondary School teacher, instructing Ministry of Education curriculum.
- Daily treatment groups, life skills instruction and ongoing individual counselling and support are also available.
- Health assessment and education, with ongoing follow-up available from paediatricians. Programming that promotes involvement with healthy non-substance related activities.

Substance Abuse Outpatient Program

- Outpatient counselors (which include social workers, art and music therapists) conduct assessments and provide short and long term individual and/or parent counselling.
- Outpatient staff are also available to facilitate education sessions around issues relating to substance use and abuse for community organizations or teams
- Health assessment and education, with ongoing follow-up available from paediatricians.

Substance Abuse Parent Support Program

Parent education and support is a core aspect of our programming. Parents are often at a point where they are no longer sure what they should or should not be doing to help their teen. They may be exhausted, managing other family and life stresses, and extremely worried about their teen. Our program counsellors provide daytime and evening consultations on an individual basis for parents of teens who have problematic substance use.

- Teens do not have to be attending counselling in the program for parents to receive service.
- Evening parent educational and support/treatment groups are offered on a frequent basis.

St. Michael's Hospital

Integrated Model of Care for Substance Use and Harm Reduction:

The day-to-day clinical team serves as a clearinghouse for addiction in the hospital and consists of addiction experts from family medicine, psychiatry, internal medicine and emergency medicine. In addition, patients are seen by and cases discussed with our case managers, nurse practitioners and, perhaps most importantly, peer support workers with lived addiction experience.

We treat all addiction types, often called in to see patients with whom engagement is difficult or who are at high risk of death or leaving hospital against medical advice. We believe that treating concurrent alcohol, stimulant and other substance use issues is key to decreasing risk of opiate use disorder (OUD) and for those with OUD it can engage them in treatment and reduce overdose risk.

For people who use opiates we offer a wide spectrum of services from harm reduction (safe injecting practices, naloxone kits etc) to evidenced based psychosocial and medical treatments. Not only are all of our treatments trauma informed, we also provide both first stage trauma treatment (through Seeking Safety and Dialectical Behavioral Therapy DBT) for individuals at the beginning of their recovery journey but also addictions-informed trauma therapy for those prepared for the later stages of trauma recovery. We have made a concerted effort to address the paucity of services available to men with traumatic experiences in their history.

This hospital's harm reduction initiatives are not exclusive from treatment but fully integrated within treatment plans. Meeting patients where they are at while solely working to build motivation for change has been effective and well received by patients and staff, decreasing frustration and increasing retention.

We are working to incorporate data-driven referrals for patients with positive urine drug screens or overdoses that will allow patients at high risk to be identified and offered addiction resources earlier in their medical journey.

Physicians in the emergency department are trained in the use of opiate replacement therapy but frequently call on our inpatient consultation team to see patients to offer comprehensive harm reduction and evidenced based psychosocial supports. Overdose, as much as possible, is managed without naloxone to reduce withdrawal in the ED and increase opportunities for engagement with the addiction team and workers. Once admitted, patients are followed closely by the inpatient team who work to reduce risk of overdose and loss of drug tolerance for high risk users, keep people in hospital and initiate medication assisted treatments. Simultaneously, patients are integrated into robust and evidence-based group therapies working to engage patients and eventually into first stage trauma therapy or more intensive therapy to overturn underlying conditions driving drug use. In some cases, appropriate family therapy is offered.

The results of the above have been dramatic. Patients revolving through the healthcare system, patients with complex medical and psychiatric problems and patients with multiple overdoses had too frequently been lost to follow-up. With our psychosocial engagement programs patients are retained in treatment and able to get, not only pain and addiction help, but also treatment for their underlying mental health concerns. A number of our physicians across disciplines are certified motivational interviewing instructors. For too long, where a patient is and who they happen to encounter has dictated the type of treatment a patient will receive.

Once discharged, patients are retained in our groups but also offered outpatient follow-up within 24-48 hours in our rapid access clinics which have been operating successfully for 5 years. Again, medication assisted treatment and psychosocial interventions are available. Our groups advance through stages from engagement to more skill-based community reinforcement approaches. We offer case management and help patients address key areas such as housing, food insecurity and referral if appropriate to inpatient treatment. Like with rehabilitation for neurologic or medical conditions we believe referral to treatment centers must be carefully timed and allocated to maximize efficacy.

For patients with addiction and pregnancy, comprehensive and innovative antenatal and addiction care is offered by members of the family health team. Many physicians in the family health team have been trained in addiction and offer addiction treatment in conjunction with primary care.

Over 50 medical trainees from all discipline lines rotate through our service annually and are jointly supervised by the interdisciplinary medical team. We believe that the bulk of the services we run can be offered by non-specialist physicians and non-physicians. Following our training, social workers or physicians have been able to set up similar groups, offer evidence-based medical treatments and harm reduction. Education extends beyond medical students and residents: we frequently give hospital rounds on harm reduction, motivational interviewing, addiction principles and opioid prescribing. Social workers and case managers from other organizations are trained in group psychotherapy and over 200 practicing physicians have received training in medication assisted treatments such as buprenorphine.

Together, we believe St. Michael's can serve as an example for comprehensive and interdisciplinary addiction care. We would like to invite any committee members or representatives of the ministry to come to St. Michael's Hospital for a site visit and to meet our team and hear these stories firsthand. (For a graphic representation of the model please see Appendix 4)

The Royal Ottawa Health Care Group

To help address the opioid use problem, we developed, implemented, and evaluated an innovative regional integrative model of concurrent disorders care for opioid detoxification and maintenance services targeted at early intervention (i.e., youth and young adults aged 16+). Our Regional Opioid Intervention Service (ROIS) is the first of its kind in Ontario, and has 4 pillars: (1) patient care and family support, (2) training, education, and capacity building, (3) integration and coordination of services, and (4) program and outcome evaluation

ROIS's multidisciplinary team provides outpatient treatment for opioid use disorders, alongside treating mental health problems. ROIS is a collaborative hub and spoke partnership, which integrates a clinic at The Royal with a network of community and hospital service providers to offer patients a full spectrum of care. ROIS also has a strong partnership with Ottawa Public Health, with a focus on harm reduction and overdose prevention and response. ROIS also provides training, mentorship, and consultation for primary care physicians, nurse practitioners, and addiction and mental health workers in order to build capacity to identify and treat opioid use

disorders throughout the region. ROIS utilizes technology, including telemedicine services, to both deliver patient care and work collaboratively with providers to build capacity.

The evaluation of ROIS indicated that despite fewer years of opioid use, youth struggle with greater drug use severity, more harmful use, more hazardous drinking, and greater mental health problems than adults. Evaluation of outcomes indicated that young people were able to access, engage, and adhere to our Service. Results highlight the need to create programs addressing the unique needs of youth with opioid use disorders, including integrating mental health and harm reduction services, in order to prevent relapse and overdoses and improve outcomes.

In terms of our capacity building initiatives, we have trained over 750 healthcare workers, including family physicians and nurse practitioners, who now have the ability to treat patients with opioid use disorders in their practices. Our Service has fostered the collaboration and integration of substance use, mental health, and primary care services, and brought care closer to where clients live, with a focus on areas where no such services previously existed. Our innovative ROIS model has built system capacity in our region, and could be applicable to other regions similarly striving to manage the opioid crisis.

In November 2013, the Ontario Ministry of Health Innovation Fund awarded ROIS the “Best Innovation in Mental Health Care Delivery.”

Vitalité Health New Brunswick

Enhancing Addiction and Mental Health Services

As part of a broader initiative, the Department of Health is working in collaboration with the two Regional Health Networks, Horizon and Vitalité and key stakeholders to develop a plan to enhance addiction and mental health services in New Brunswick. Part of this work involves reviewing the current Addiction and Mental Health programs and services along the existing continuum of care, reviewing best and promising practices in the literature and in other jurisdictions, and developing a plan to ensure that New Brunswick’s continuum of services in addiction and mental health are aligned with best practice and meet the various levels of need that individuals accessing services require.

Eastern Health

Improving access to Suboxone – Planning is underway to expand/enhance opioid dependence treatment options, including increasing availability of suboxone. In December 2016, Minister of Health & Community Services announced open access to suboxone, thus removing the requirement for special authorization under the NL Prescription Drug program. Eastern Health is currently working with its physician group to identify potential prescribers and in partnership with Memorial University, has been working on a training program for physicians, nurse practitioners, pharmacists and allied health professionals.

Mental Health Commission of Canada

Housing First for active substance users co- morbid with mental health problems and illnesses - Findings of At Home- Chez Soi study:

At Home-Chez Soi was a five-city, four-year randomized control research demonstration project on mental health and homelessness that demonstrated and evaluated the effectiveness of the "housing first" approach,

for experiencing homelessness, mental health and/or substance use problems. In this approach people are provided with a place to live and then receive recovery-oriented services and supports that best meet their individual needs. The Vancouver site project had a particular focus on those who also had challenges with substance use.

The Vancouver site sample included 497 participants recruited from a wide variety of community and institutional settings, 72 percent of whom were absolutely homeless. Substance use was observed among 58 percent of the participants and 52 percent reported two or more mental health problems or illnesses.

This site study consisted of two parallel randomized control trials differentiated by intensity of support provided in the intervention. The moderate needs group included 100 participants randomly assigned to intervention groups including scattered Housing First housing and Intensive Case Management, and 100 participants assigned to “treatment as usual”, who did not receive housing or supports through the study but continued to have access to a wide array of existing services. The high needs group was made of the remaining 297 participants, 100 of which were assigned to treatment as usual, 90 to housing first scattered sites with Assertive Community Treatment, and 107 participants were assigned to a congregate housing with onsite supports. Despite the transient nature and the complex challenges faced by the participants, there was a 90 percent follow up in intervention groups and 75 percent follow up in the treatment as usual groups.

The study overall demonstrated significant cost effectiveness of implementing Housing First approaches, but most importantly effectiveness in improving health, housing stability, public safety, and quality of life of people experiencing homelessness alongside mental health and/or comorbid substance use challenges. Unpublished results also indicate significant improvements from baseline in interviewer rated community functioning over the course of the study. The Vancouver site’s Peer Reference Group also produced its own report about its experience in the study and provides recommendations with respect to peer support training for people experiencing mental health issues, homelessness and/or transitioning from homelessness, and/or addiction.

Collaboration for Addiction and Mental Health Care:

The co-occurrence of addiction, mental health problems and physical co-morbidity is very common and particularly challenging to address. Effective collaboration strategies at the practice level in addiction and mental health care are still in early stages of development, evaluation, and knowledge translation. This is despite the momentum for integration of mental health and addiction sectors at the systems level, and the strong evidence that collaboration among providers is a best practice for a range of health issues. A recent report issued by the Canadian Executive Council on Addictions (CECA), the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Abuse (CCSA) identifies key elements of collaboration to help service providers collaborate effectively in addressing mental health and addiction needs.

In 2012, CCSA, MHCC and CECA created a partnership to research and build consensus on effective strategies for collaboration between mental health and addiction services. It was supported by a Scientific Advisory Committee. Researchers, administrators, direct service providers and persons with lived experience of mental illness or addiction from across Canada were engaged to review the available evidence in the context of their own experience and jurisdictions, and to explore strategies for practice and research. A best advice document, “Collaboration for Addiction and Mental Health Care: Best Advice”, was published in 2014. It was updated in 2015 with additional examples of good practices in collaboration in addiction and mental health care.

The literature on collaborative care covers different sectors and services, varying forms or models of collaboration, and assorted targeted outcomes, which made it difficult to identify tidy “proof points” of what works best for collaboration between addiction and mental health under specific programmatic and contextual

conditions. Rather, the evidence, pointed to key principles, considerations and elements of collaboration that can successfully support service providers.

The key benefits of collaboration include enhanced capacity to support people with complex conditions, improved access to services, earlier detection and intervention, integrated clinical care, improved continuity of care; larger return on investment, more satisfied healthcare consumers, and improved client-patient outcomes with reduced costs.

Models with the most traction to date include the Canadian Collaborative Working Group on Shared Mental Health Care approach, the Chronic Care Model, the Tiered Model and the Comprehensive, Continuous, Integrated System of Care Model. Their shared features include: effective linkages, high level of trust and reciprocity among participants, focus on the broad continuum of severity, multi-sectoral involvement, multiple levels of collaboration that align with different types of needs and levels of severity, and a distinction between service- and system-level initiatives.

The report suggests six areas for action to better support of collaborative work: (a) support providers in dealing with change and its barriers; (b) prioritize initiatives that build collaborative relationships; (c) improve knowledge and ability to screen and assess for co-occurring mental health and substance use risks or problems; (d) view treatment through an integrated, holistic and strength-based, recovery oriented/patient centred lens and by coordinating care in active, complementary ways across the stages and phases of care; (e) build capacity for collaboration, especially through human resources and technology; and, (f) evaluation.

A key theme that emerged from the consultations was that everyone, across multiple sectors and at all levels, has a role and responsibility to support and advocate for collaboration to improve access to services and outcomes for people with mental health and addiction-related problems.

APPENDIX 4: ST. MICHAEL'S INTEGRATED MODEL OF CARE FOR SUBSTANCE USE AND HARM REDUCTION

Integrated Model of Care for Substance Use and Harm Reduction *"No wrong door to treatment"*

Emergency Department

- assessment and treatment as per patient need (medical, mental health, trauma, pain and addictions)
- harm reduction – safe supplies, Naloxone kits, education
- automatic referral to Harm Reduction and Addictions Service when Naloxone, Suboxone, CIWA or positive drug screen
- data driven case finding
- Addictions Service – physicians, nurse practitioners, counsellors, peer support workers
- managing transitions - referral to continuing care - addictions clinic, housing, case managers, job retraining

Withdrawal Management Services

- Home Detox** – assessment for acuity of addiction and readiness for change – assessment medical, mental health, trauma, pain and addiction
- harm reduction -Naloxone kits, education
- physician support, case management, peer support
- Day Program Detox** – many locations, providing medical, pharmacological and evidenced based psychosocial support
- Residential Treatment Centers** – 1 – 6 months in transitional housing after acute stabilization in medical detox center
- Above includes medical, pharmacological and evidenced based psychosocial support

Public Health

- harm reduction supplies
- staff / client education
- safe consumption sites – testing drug content
- community advocacy and outreach

Complex Care Clinic

- complex case management
- harm reduction and engagement in treatment
- peer support workers connect when clients are hard to reach
- co-localized treatment for medical and psychiatric co-morbidities
- complex psychosocial interventions
- treatment of concurrent illness – eg personality disorder, PTSD

Rapid Access Clinic – Low Barrier Engagement

- Triage/assess acuity of addiction and client needs
- Assess/ reassess need for anti-craving medications
- Provide evidenced based addictions counselling
- Harm reduction – clean supplies and Naloxone kits
- Initiate, reassess and adjust Opioid Replacement Therapy
- Referrals to other services in community for ongoing support
- Shared care clinics

Inpatient Medicine/Mental Health Unit

- assessment and treatment as per patient need (medical, mental health, trauma, pain and addictions)
- shared care between medicine/psychiatry
- harm reduction – safe injection on unit, alcohol management
- opioids to protect tolerance and minimize risk of AMA
- Suboxone /Methadone
- anti-craving medication
- addictions counsellors, peer support workers, dialectical behavioral therapy
- menu of options for psychotherapy
- advocacy for treatment of medical illness

Supporting Transitions to community resources

- housing
- day programs
- case managers
- peer support
- family support
- job retraining
- harm reduction
- continuing care
- education

Family Health Teams – Community Health Centers

- assessment of need –medical , mental health, trauma, pain and addictions
- harm reduction – safe supplies, Naloxone kit
- anti-craving medication
- integrated treatment of medical and psychiatric conditions with expert support as needed
- evidence based psychosocial interventions

APPENDIX 5: CONTRIBUTORS

- Alberta Health Services
- British Columbia College of Family Physicians
- Canadian Association of Paediatric Health Centres
- Canadian Centre on Substance Use and Addiction
- Eastern Health
- First Nations Health Authority
- Fraser Health Authority
- Hamilton Health Sciences
- Interior Health
- Island Health
- IWK Health Centre
 - IWK Regional Poison Centre
- Mental Health Commission of Canada
- Nova Scotia Health Authority
- Providence Health Care
 - British Columbia Centre on Substance Use
 - Crosstown Clinic
- Provincial Health Services Authority
 - British Columbia Centre for Disease Control
 - British Columbia Emergency Health Services
 - British Columbia Mental Health and Substance Use Services
- St. Michael's Hospital
- Sioux Lookout First Nations Health Authority
- The Hospital for Sick Children
- The Royal Ottawa
- Thunderbird Partnership Foundation
- University Health Network
- Vancouver Coastal Health
- Vitalité Health New Brunswick
- Winnipeg Regional Health Authority
- Yukon Hospital Corporation