



The Overdose Crisis Where to Next?

Community Voices from the May 10, 2017, Symposium

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Welcome to the territory:

Butch Dick, Songhees Nation

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Songhees Wellness Centre

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Tsow-Tun Le Lum Society

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Society of Living Illicit Drug Users (SOLID)
Island Health Authority
First Nations Health Authority
Moms Stop the Harm
Umbrella Society
PEERS
Centre for Addictions Research of BC
Victoria Cool Aid Society
Portland Hotel Society
Tsow-Tun Le Lum Society
Victoria Native Friendship Centre
Surrounded by Cedar
South Island Wellness Society
City of Victoria
Cowichan Tribes
Binkadi Community Services
STS Pain Pharmacy
Victoria Youth Clinic
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Community Social Planning Council
Parents, family members and people with lived experience of illicit drug use

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INTRODUCTION

It has been over a year since BC declared a public health emergency due to the number of people dying from accidental overdoses. In 2016, 967 people died in BC – an 80% increase over 2015 – and 158 of them occurred within the Island Health region.¹ Despite best efforts on the part of many, more than 600 people have already lost their lives this year, 41 of them in Victoria alone.² The impact of these losses is profound, touching families, communities, and those working on the frontlines of this crisis.

On May 10, 2017, AIDS Vancouver Island (AVI), with the support and collaboration of the Community Action Initiative (CAI) hosted an event at the Songhees Health Centre to ask the important question: “Where to next?” The symposium provided community members and service providers with an opportunity to reflect on the crisis and to engage in dialogue about the short and long term actions needed to turn the tide of overdoses in our community.

Significant efforts are being made out across Vancouver Island – to inform the public and key populations of how to prevent overdoses, to expand access to overdose response services, to improve treatment options, to advocate for policy change, and to support those who have experienced loss. Yet, the most recent Coroners report from May 31st of this year illustrates a startling 158% increase in overdose deaths from May 2016. There is a sense of frustration on the part of those most central to this crisis – namely people who use drugs, their families, and those frontline workers charged with caring for both. This frustration stems from feeling that they are not being considered in decision-making processes that directly affect them and knowing that if community-level knowledge was included a greater understanding could be developed around why some approaches fall short of what is needed to help those most affected.

Over 100 people came together at the symposium, with the goal of honouring the work being done, caring for each other, and finding a way through this highly complex time. We came together because we are feeling anger, despair, overwhelm, and devastation. We came together to pool hope, find reprieve from feelings of isolation, to join forces, learn from each other, and to chart a path forward. And, by coming together, we found strength in solidarity.

This report summarizes the voices of people who live with the crisis everyday and who want to be heard. While there were acknowledgements of the work being done by the Province of British Columbia and by the Island Health Authority, those in attendance primarily represented the community-level response. A response being led by people who use drugs, families who have lost loved ones, community organizations, and front-line staff who’ve been working tirelessly in the face of tragedy and grief. The voices that resonated at this symposium were those of a community coming together to find healing and to forge a path forward together, articulating what those in the community-led response need to be able to continue to play their important roles in addressing stigma and saving lives. If progress is to be made, these voices, insights, and perspectives need to be heard.

1 <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

2 <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

Part 1: Creating Supportive Communities

A. Addressing Stigma and Increasing Public Awareness

Beyond direct services, efforts to address overdose are also focused on creating supportive communities and services, and addressing stigma was identified as the most significant areas of challenge. Stigma permeates every part of the health care system and our communities and keeps drug use hidden. Stigma prevents people who use illicit drugs from accessing services, it makes it difficult to find neighbourhoods where new services can be located, and it impacts the families and friends of people who use drugs or who have died of overdose.

Public attention needs to remain focused on the overdose crisis and we need to continue to build awareness about overdose risk, reduce stigma, express the public outrage about the situation, build community support and political will for the necessary actions, and to find ways to share stories and hold the collective grief communities are experiencing.

The challenges of stigma:

- In seeking to address overdose deaths, it's essential to address the social and personal stigma and discrimination associated with substance use and addiction. Stigma around drug use is deeply embedded in the structures of our society, and rooted in Canada's history of prohibition and evidenced in current drug policies. As long as drug use is criminalized, stigma will persist.
- Advocating for changes to drug policies is an essential element to the overdose response because the criminalization of drug use ensures the existence of an illegal market that will continue to be contaminated, if not by fentanyl then by other dangerous additives. Cannabis legalization represents a step in the right direction and could offer an opportunity to shift stigma around other substances.
- Stigma is enacted in many settings, from online forums, to schools, to hospitals. It is also not only linked to stereotypes around drug use, but also to mental illness, HIV/AIDS, hepatitis C, poverty, and culture/race. Some people therefore experience stigma and oppression in multiple, intersecting ways. Addressing stigma relating to drug use therefore requires an intersectional approach that takes other stigmas and oppressions into account.
- In developing responses to stigma, we need to look for allies in the community who want to be part of the solution and who haven't yet reached out to. Recently AVI held a very successful naloxone training event at Logan's Pub, which brought out unexpected expressions of solidarity. Community members expressed a desire to have more support in learning how to stand up and speak up and to address stigma in their social circles, workplaces and neighbourhoods. Stories are an important tool to promote compassion and fight stigma.
- School-based education is an opportunity to prevent stigma – teachers need to be included so that their understanding of addiction and substance use is improved and so that they can contribute to efforts to fight stigma.
- For stigma within the health care system, naloxone training could be an opportunity to educate about the impacts of stigma. Another possibility would be to develop an "opioid sensitivity training" based on the model of the Indigenous cultural safety training offered by the Provincial Health Services Authority for doctors and other health care professionals.

Public education and raising awareness:

- The voices of people who are affected by the crisis (such as peers and families) need to be heard, creating safe spaces for stories to be shared that show the human side of the epidemic. As noted above, resources for allies to empower them to speak within their communities to build awareness about overdose risk would be welcomed.
- Although important, provincial government overdose information websites and advertising are not enough. Fear-based campaigns don't work and there is a need for funded community-based education initiatives that are adapted to the local context and culture. Targeted approaches are needed for diverse audiences: schools, universities, teachers, police, politicians, emergency responders, healthcare professionals, Indigenous communities, and the entertainment sector (festival organizers, event organizers, bartenders, etc.).
- As noted elsewhere, informational resources are needed about how to access support, where to get naloxone training, what services are available, etc. Communities need easy access to a list of resources, for example the Street Survival Guide or an interactive map of provincial resources.
- There needs to be more promotion of what resources may be available on a local level that can be easily accessed. For example, the BCCDC Toward the Heart website provides an easy way to find Naloxone, safer sex/drug supplies and local Overdose Prevention Sites. <http://towardtheheart.com/>

B. Supporting Front-Line Workers and Families

Supporting those working on the frontlines:

- There is currently an informal "chain of support" for grief – supervisors are supporting frontline staff, frontline staff are supporting each other and clients, etc. – which lacks intentionality and is not meeting needs. Approaches by management are not always appropriate or safe – feelings cannot be scheduled and mandatory staff meetings to discuss grief are not seen as safe or helpful.
- Workers are overstretched and accessing support feels like one more thing to do in their day. Some also struggle to create a separation with their home lives so that they can have a space that is safe from grief and triggers.
- Staff need to be asked what would work for them. Peer workers fall through the cracks and may need different supports than non-peer staff. A needs assessment may be helpful, as well as the creation of a support network and the expansion of the PORT (Palliative Outreach Resource Team).
- There's a need for grief support services that are appropriate for this context (i.e. provided by people who understand the context of working around drug use, overdose, etc., and the impacts of compounded grief). Long-term strategies are needed because unfortunately the end to the overdose epidemic is nowhere in sight, and workers are experiencing compound grief which may impact their health both inside and outside the workplace.
- Several strategies that have been helpful were identified, including: accessing external support and counselling; organizing events for people from all agencies to come together to feast together and celebrate life; engaging in social justice activism outside of work as an outlet; celebrating small victories; and finding ways to speak about what's happening.

Supporting families:

- Family members feel the burden is on them to advocate for their loved ones to get the support they need.
- There needs to be a recognition that providing support to families is critical and missing from the system.
- Many people don't know where to access support or help for their loved ones. Some family members who want to play a greater role in this support but feel they lack the capacity or resources to do so. For those that can successfully navigate the system for their loved ones, there are times the system fails, especially during transition times.
- The perspectives of family members need to be included at every level along with the recognition they can be an important resource for service providers
- Family members are also first responders, providing tailored overdose response training and support is needed

C: Supporting Indigenous People and Communities

Indigenous people and communities have been disproportionately impacted by overdose. There's a need to indigenize harm reduction and large strides need to be made within the overdose response so that the needs of Indigenous people are met. Creating a parallel system for Indigenous people is not the right approach – the current system needs to work for all people who use drugs.

Indigenous people and communities have been disproportionately impacted by overdose.

- Indigenous people should be at the table for all discussions about services for Indigenous people and Elders should be engaged to develop the system in Indigenous ways.
- Indigenous cultural safety training³ should be mandatory for all frontline workers, service providers, and health care workers.
- Priorities that were discussed included: special focus on reaching Indigenous people who are experiencing homelessness, better coordination of services, the need for long-term outreach teams, case management, and culturally sensitive supports. A range of services and agencies need to be available, offering multiple access points, and coordinated support services should be in place while people wait to access treatment or other services, so that Indigenous people are not falling through the cracks.
- Further dialogue and a community forum focused on how to address overdose within Indigenous communities is needed.
- Processes should be face-to-face when possible with adequate time allocated so that Elders can take the time they need; circles end when the business is done.

³ San'yas Indigenous Cultural Safety Training is an online program: <http://www.sanyas.ca/> offered by the Provincial Health Services Authority of BC (PHSA). The national Indigenous Cultural Safety Learning Series, developed by the PHSA and partners, is a monthly webinar series focused on Indigenous cultural safety that offers additional learning opportunities: <http://www.icscollaborative.com/webinars>

- Appreciation was expressed for the desire of non-Indigenous peoples to build relationships with Indigenous communities and to work together on solutions.
- The First Nations Health Authority (FNHA) has developed workshops on “Indigenizing Harm Reduction” that are available to communities

D. Supporting Youth, People who are Incarcerated, and Reaching Hidden Populations

Meeting the unique needs of different populations is one of the challenges of formulating a robust overdose prevention and support response. Attendees offered suggestions on how better to meet the needs of youth and people in prisons (or those transitioning from prisons), and how to reach populations of people who use drugs that may not be accessing services. Overall, targeted approaches that meet the unique needs of different individuals, where possible, can help to fill these gaps by making every door the right door.

Service needs for youth:

- There are concerns about youth being served at the same sites as adults, about what services are youth-friendly and appropriate, and how service providers can meet the challenges that arise when serving this population. As noted above, youth-focused withdrawal management options are needed.⁴
- There are limited youth harm reduction options in Greater Victoria. Youth are presenting at adult services where there may not be the appropriate level of support but there are few referral options. Overdose prevention services that are located within shelters or housing are not available to people under 19.
- Early intervention with youth who are using illicit substances is crucial and services need to be provided where the youth are at.

The needs of people who are incarcerated:

- Overdose prevention education by community agencies is being offered in prison. However, access to naloxone is limited and education therefore focuses on alternative measures for overdose prevention, such as rescue breathing. When overdoses happen, people are reluctant to alert a guard because for fear of being penalized.
- Incarcerated individuals are experiencing challenges in accessing opioid substitution therapy. There may be an opportunity to change this when the PHSA takes over prison health services.
- When people are released from prison, they are at risk of an overdose. People are presenting at community services requesting assistance. This is an important time to providing for overdose awareness education, naloxone training, and seamless referral to other services.

⁴ In March, the Ministry of Health released new withdrawal management guidelines for youth: <http://www.health.gov.bc.ca/library/publications/year/2017/youth-withdrawal-management-guidelines-final.pdf>

Building bridges into “hidden” populations:

- There is significant concern about people who are not accessing services from harm reduction services or their family doctors, and who may use substances regularly or only occasionally. Many questions remain, such as: How do you reach people who are primarily using at home or those whose work schedules do not allow them to readily access services?
- Reaching hidden populations may require different approaches, for example, locating services outside of downtown, in multi-purpose buildings, or with other services (which also might be more cost-effective). Mobile support services and naloxone training might be an option for reaching hidden populations. The West Shore and Sooke was noted as a community where there is a significant gap in services for hidden populations.
- University students also represent a group that may not be reached by current interventions. Many students are engaged in substance use (Ritalin was mentioned as a substance used by many students). Targeted approaches may be needed to reach students with information and services.
- Province-wide social marketing strategies do not necessarily meet the messaging needs of local communities. Public education aimed at hidden populations needs to be culturally relevant for the audience and located in places where they go (coffee shops, pubs, etc). For hidden populations, it is important for social marketing campaigns to mention that it is not just heroin, but other substances as well.
- Summer is festival season and service providers are doing the best they can to offer support to festival organizers with naloxone training and other information. However, there is concern about whether enough is being done to prevent overdoses in this context, especially considering new data that fentanyl has been detected within more than half of samples of MDMA and cocaine tested by a local pharmacy.⁵ Drug checking services could be offered at festivals as a harm reduction measure.⁶

5 <http://www.cheknews.ca/victoria-pharmacy-finds-fentanyl-half-mdma-cocaine-samples-325871/>

6 ANKORS, a community-based organization in the Kootenays has published a guide to drug testing at festivals: <http://www.ankorsvolunteer.com/drug-checking-information.html>

Part 2: Community-Level Overdose Prevention Services

A. Harm Reduction Interventions to Prevent Overdoses

For many people who use drugs, harm reduction services are an important entry point for connecting into services. Harm reduction services, such as needle distribution, while available in Victoria for over 20 years, have evolved significantly in the last decade – serving thousands of people every year and providing multiple entry points for accessing harm reduction supplies, education and information, and connecting with support workers.

These services are ground zero of the overdose response, sharing critical information about spikes in overdoses, providing naloxone training, and referrals to other services. Harm reduction interventions to prevent overdoses include: harm reduction education and support; relationship-building and referrals; naloxone training and access; supervised consumption services (SCS) and overdose prevention sites (OPS); drug checking; and targeted approaches for specific populations.

Harm reduction, overdose prevention sites, and naloxone:

- There remains an urgent need to tailor services to reach anyone who is at risk of an overdose regardless of their social or economic circumstances or cultural identity in ways that feel safe for them. The concept of cultural safety was first developed to improve care for Indigenous populations and there is a growing recognition that cultural safety can be extended to other contexts, such as for services for people who use drugs,⁷ meaning that the services consider how past histories of trauma and violence may affect patients' ability to access services and supports.
- The design of harm reduction services, including for overdose prevention sites, should consider the needs of different kinds of service users and provide diverse, low-barrier options. This may mean providing some specialised services primarily for people who use drugs, or to offer services in multipurpose buildings so that accessibility is increased and anonymity/privacy is preserved. Geographic placement of services is also important. Currently overdose prevention sites and clinics where opioid substitution therapy can be accessed are concentrated in Victoria's downtown. Services are needed in the West Shore, Sooke, and Esquimalt.⁸
- Community-level overdose prevention services can be nimble and shift or adapt quickly when resources are available or innovative activities need to be rapidly implemented or piloted. It should be noted, however, that this flexibility should not be taken for granted and should be resourced appropriately so that organizations aren't stretched further.
- Although there have been many strides made to extend the reach of naloxone, efforts must be sustained and the reach expanded to more hidden populations of people who use drugs, which may require thinking outside the box.

7 Paulie, Bernie, Jane McCall, Cat McLaren, Anette J. Brown, Asheley Mollison. (2013). "Creating Culturally Safe Care in Hospital Settings for People who Use(d) Illicit Drugs," Centre for Addictions Research of BC, Bulletin #11. <https://www.uvic.ca/research/centres/carbc/assets/docs/bulletin11-creating-culturally-safe-care.pdf>

8 A survey conducted in 2016 by Bruce Wallace (UVic School of Social Work and the Centre of Addictions Research of BC), found that Esquimalt was the second choice for where to access supervised consumption services. Dr. Wallace presented these findings at the Symposium.

Ideas put forward included pairing naloxone training with first aid training and hosting trainings at places where people feel comfortable (for example, at bars or cafes).

- Information on where to get a naloxone kit or to participate in trainings needs to be more widely promoted within the community.⁹ Also, refresher trainings on how to use naloxone would be helpful for people who received the training over six months ago. Many people require ongoing support to respond to overdoses.
- Overdose prevention sites have been important additions to the response and have no doubt led to many lives being saved. Greater consistency between how sites operate may need to be considered to improve their effectiveness. For example, rules and protocols differ between sites, which can be confusing and frustrating for clients.
- Drug checking services are needed at community-level harm reduction sites, overdose prevention sites, as well as at summer music festivals, and other key locations.
- Staff working at community-level harm reduction services are often the first line of response. The daily realities of the overdose crisis are a heavy burden. Organizations are learning how to better support staff,¹⁰ but need more resources to do so.
- Staff – both peer and non-peer – working in harm reduction services hold a tremendous amount of skills, knowledge and information and are great assets within the response. However, there is the feeling that their expertise is not valued by other levels within the response, and this sense of being undervalued creates an additional burden on staff.

B. Pathways to Addiction Services and Support

While not all people who use substances struggle with addiction, those who are habituated to substances may choose to access services such as opioid agonist therapy (OAT), withdrawal management, and treatment. OAT offers people access to safe opioids through prescription so that they do not have to use substances procured from the illicit market, which could be tainted and increase their risk of overdose.

Until recently, the primary available substitution therapy has been methadone, but more recently suboxone (buprenorphine/naloxone) has become first line treatment. As well, there is promising evidence of the effectiveness of hydromorphone and heroin prescription, although these are not yet available in Victoria.

Access to Opioid Agonist Therapy:

- The OAT component of the OD response system is an essential and important service for those struggling with addictions to opioids. New therapies are becoming available alongside established therapies (such as methadone), each with their own guidelines for prescription. There are several clinics in Victoria that offer access to OAT, however some serious barriers to access exist. For example, there is no one central resource or referral system to clinics, complex regulations and guidelines around prescriptions make the system hard to navigate (not all physicians can prescribe all substitution therapies), and each clinic has different intake and other criteria for service access.

9 This information is currently available on the provincial government website: <http://www2.gov.bc.ca/gov/content/overdose/where-can-i-get-a-naloxone-kit>

10 Toward the Heart has published a resource to guide organizations in supporting staff who are administering naloxone: *Take Home Naloxone: A Guide to Promote Staff Resiliency & Prevent Distress after an Overdose Reversal*. http://towardtheheart.com/assets/naloxone/naloxone-staff-resiliency-final_185.pdf

- The recently opened Rapid Access Addiction Clinic (RAAC)¹¹ is an important new service whose potential has yet to be maximized. Currently, clients presenting at other clinics or services who are then referred to RAAC, do not always present to the RAAC and are falling through the cracks. More information is needed about why this may be happening so that more seamless referral or navigation supports can be provided.
- Additional primary care physicians, nurses, and pharmacists need to access the available education programs on therapies, regulations and guidelines from the College of Physicians and College of Pharmacists, and how to prescribe or support patients to access OAT.¹² Family physicians are being encouraged to take steps to becoming prescribers so that access to OAT can be expanded.
- Plan G (available to B.C. residents of any age who demonstrate clinical and financial need) is now covering suboxone (in addition to methadone and naloxone). However, many physicians seem to be unaware of this change.
- Stigma continues to be a barrier to accessing OAT especially in settings like hospitals. Negative experiences in hospitals or clinics can lead people to avoid seeking care or to leave before their care is complete. Complaints processes should be accessible so that incidents can be reported and addressed. Additionally, there is a concern that if those within primary care are not using, or willing to use, the tools available, greater progress to reduce overdoses will be difficult to achieve.
- Patients need support navigating the system and obtaining accurate information about OAT. In addition to information to support patients to understand their options – such as the *OAT Handbook for Patients* published by CARBC¹³ – a list of where to access OAT, what is required for intake (i.e. whether identification is needed), clinic hours, etc., would be helpful for both patients and the service providers supporting them.
- Activism at the community level may be required to bring attention to what is not working and to advocate for expanded, low-barrier access to OAT, particularly on the West Shore, and for hydromorphone (prescription heroin) access in Greater Victoria.
- Many people require assistance to remain connected to their OAT service especially during the initial stages of treatment. The Cool Aid Health Clinic and AVI have recently started a support group for people on OAT. More supports such as this are needed to help people navigate their experiences, connect with peers, and obtain referrals and other supports.
- OAT access is limited within prisons and there may be an opportunity to change this when the Provincial Health Services Authority assumes responsibility for prison health services.

11 The Rapid Access Addiction Clinic (RAAC) supports individuals with opioid use disorder by starting and maintaining clients on opioid agonist (replacement) therapy (Buprenorphine/Naloxone/Suboxone). http://www.viha.ca/mhas/locations/victoria_gulf/community/vwms.htm

12 The BC Centre on Substance Use has published a clinical management guidance document (http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf) and is offering online training through the Provincial Opioid Addiction Treatment Support Program (<http://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/>), which is geared at opioid agonist treatment prescribers, including both physicians and nurse practitioners, however, all health care providers (e.g., nurses, pharmacists, social worker, counsellors, etc.) can benefit from the online education modules.

13 In 2016, CARBC released an OAT Handbook for Patients: <http://www.uvic.ca/research/centres/carbc/assets/docs/ost-patient.pdf>

Withdrawal management and treatment services:

- There are gaps in withdrawal management services (i.e. “detox”) with regards to: the number of beds available; services for youth; and services outside of Victoria (such as on the West Shore).¹⁴ Additional options need to be considered, such as home-based withdrawal management for those who do not require medically-supervised withdrawal management and increased access hospital-based withdrawal management for those who need additional medical support. Frustration was also expressed regarding the fact that the detox unit in Victoria sometimes has beds sitting empty while people wait for services because they do not have a process if people do not show up or cancel.
- While withdrawal management services are important, there are concerns that people who enter “detox” are much more likely to overdose than those who continue using or who access OAT, because of reduced tolerance following discharge.¹⁵ As a harm reduction measure, the detox unit has started providing naloxone kits upon discharge and access to OAT is being offered as an alternative to detox that can support clients to stabilize, reduce their use of street drugs, and access care and support.
- There isn’t much of a “system” or continuum of care for withdrawal management and treatment services. There is confusion about what services are currently available, what the intake and discharge procedures are, and how to support clients to navigate an uncoordinated system. Opportunities to maintain health are lost when clients cannot be readily discharged to stable housing or second stage treatment.
- There is the perception that information about withdrawal management and treatment options is not readily accessible; people expressed a lack of clarity as to the eligibility requirements, intake processes, treatment options and discharge approaches
- Accessing treatment is a challenging process for many and an impossible process for others. It requires that you know where you want to end up and work backwards, which isn’t realistic for patients. Also, each treatment centre has its own application forms and it is challenging for patients to fill out multiple different forms and to keep track of what’s required for each, and waiting lists can be long.
- There are not enough treatment options for patients on Vancouver Island and seeking treatment on the lower mainland is a barrier for some people. Additionally, culturally appropriate or specialized treatment care are rare and difficult to access. There is a need for: culturally appropriate treatment services for Indigenous people; treatment programs that address underlying traumas; and treatment facilities that can offer support people with mental health as well as addictions challenges.
- A “no wrong door” policy could be a solution wherein wherever a patient first presents for support they are assisted in navigating the system and not simply referred somewhere else. Case management approach might be beneficial and peer navigation supports could be expanded.
- In some cases, service integration and/or collaboration is effective, for example the 713 team with AVI and Island Health and Umbrella working with Island Health for the SAMI team and RAAC. Each organization brings their strengths to the table – for example, community-level services can be nimble and health authority-based services serve as the gatekeepers to detox and treatment.

14 Withdrawal management services provided by Island Health are listed online: http://www.viha.ca/mhas/locations/victoria_gulf/community/vwms.htm

15 As the first point of engagement in clinical care, opioid withdrawal management can serve an important role as a bridge to treatment, but provincial guidelines do not recommend this approach unless a strategy is in place for referral to ongoing addiction treatment (e.g., intensive outpatient treatment, residential treatment, access to long-term opioid agonist treatment, or antagonist treatment). http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/bc_oud_guidelines.pdf

- Currently there is not enough support for patients during transition points between withdrawal services, treatment, and discharge and this is leading to unintended harms. These are important intervention points for overdose prevention because tolerance is reduced. Also, for people who need withdrawal management services, currently they are discharged after seven days, and if they are waiting for treatment, they must be sober for two weeks. The week between being discharged from withdrawal management services and entering treatment is a gap in support that needs to be addressed to decrease the risk of overdose for these patients.
- Support is needed for families of people in/exiting treatment and patients need more assistance to support them in their planning for life after treatment (for example job training support).
- Stigma around substance use has an impact on the individual and their community. For example, stigma can mean that people don't access help or hide their drug use, and at the community-level, NIMBY (not in my back yard) attitudes make it difficult to open new services.
- Relapses are a normal part of recovery and therefore need to be talked about openly so that there is less stigma and people can reach out for help without feeling shame or fear of consequences (such as losing their housing).
- Provincial social assistance does not pay for housing to be maintained while people are in treatment, so sometimes people must choose between treatment or maintaining housing, and are at risk of being homeless upon discharge.

C. Creating Safety in Housing

The province recently reported that the majority of fatal illicit drug overdoses in 2017 occurred indoors, with over 50% of them in private residences and nearly 30% in other residences.¹⁶ Therefore, while overdose prevention sites and other harm reduction measures are certainly preventing some overdoses from happening, more needs to be done to address the needs of people who use drugs at home.

Approaches to create safety in housing:

- In order to develop a response that is data-driven, a Victoria-specific breakdown of this information is needed to understand the particulars around where overdoses are taking place, for example whether overdoses are happening within shelters, supportive housing, or other types of residences.
- Several housing services in Victoria have come a long way in their implementation of harm reduction services. However, many challenges remain for overdose prevention in housing services. An open dialogue is needed to explore how to better integrate overdose prevention and harm reduction into housing services. Questions that could be addressed include: How do we create safety? What's the role of housing staff? What is the role of residents? How do we balance privacy with safety? Are the rules of funders or a lack of resources impacting how organizations can implement measures to reduce overdose risk? How are policies put in place that are intended to increase safety for residents, such as "no guest" policies, having unintended consequences? What's working well?
- Policies within supportive housing that are developed with good intentions sometimes have unintended consequences when it comes to overdose prevention. On the one hand, abstinence-focused programs can be helpful for individuals who want to live in "dry" housing, but on the other hand, fear of losing one's housing can lead to "hid-

16 <http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf>

den” drug use in these facilities and increased overdose risk. While there are housing facilities where use is permitted, service providers may not be able to be responsive to the challenges arising, such as overdose risk.

- This crisis has been particularly challenging for staff in housing facilities. It is not always clear what is expected of them in terms of overdose prevention and the stress that comes with anticipating possible overdose deaths is burdensome. While the community understands that it is not always helpful to say that more supports or funding is needed, what was put in place a year ago, to support people in housing is simply no longer enough in this current crisis. When housing staff are enabled to support each person with their unique needs (for example individualized safety plans), better outcomes are achieved, but this requires resources.

Evaluation quotes

“It was a fabulous day. I was emotionally exhausted and inspired at the same time.”

“This was a very powerful and moving event. I appreciated everyone who came out and shared their stories.”

“I think this was a very important event and we should be having them at least bi-annually if not quarterly to facilitate a continued community response in the face of the ongoing crisis.”



**Organized by AIDS Vancouver Island and the Community Action Initiative (CAI).
For more information about this initiative call Clare at 1-800-665-2437**