A PRACTICE BRIEF

IMPLEMENTING THE VICTORIA SAFER INITIATIVE

coLab
University of Victoria | Canadian Institute for Substance Use Research
Solid Outreach Victoria BC
Victoria safer Initiative
AVI Health and Community Services
where harm reduction works

Purpose

This series provides practice-based and community-informed knowledge regarding implementation of critical substance-use services and supports, including treatment and harm reduction programs that meet the needs of people who use drugs.

Objectives

- To promote community-informed knowledge related to essential substance use services.
- To guide decision makers and practitioners in making policies and designing community-informed services related to substance use services and supports.

About Co/Lab

Co/Lab is a collaborative network for research and knowledge exchange that aims to promote health and health equity for people who use drugs (including alcohol, other licit, and illicit drugs). Co/Lab activities are guided by collaborations with people who use drugs, families, health care providers, researchers and policy makers, and are focused on generating practical evidence that can be used to enhance substance use services and supporting policies.

This initiative has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

The views expressed in this brief are solely those of the authors.

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Suggested Citation

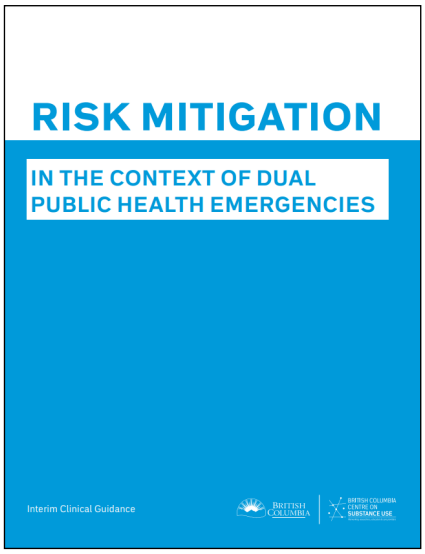
Ranger, C., Hobbs, H., Cameron, F., Stuart, H., McCall, J. Sullivan, G., Urbanoski, K., Slaunwhite, A., &Pauly, B. (2021). "Co/Lab Practice Brief: Implementing the Victoria SAFER Initiative." Canadian Institute for Substance Use Research, University of Victoria, Victoria, Canada.

Practice Brief: Implementing the Victoria SAFER Initiative

Background

Almost 20,000 people have died of toxic drug poisoning in Canada since 2016 with 7000 deaths occurring in British Columbia (BC) alone. A provincial public health emergency was declared in 2016 due to the rise in fatal overdoses primarily due to fentanyl and other contaminants. In 2019 the annual number of illicit drug toxicity deaths[1] fell below 1000 for the first time since 2016. Subsequently, in 2020-21, non-fatal and fatal overdose events escalated once again, with more than 1700 people dying from illegal drug toxicity in 2020. Currently, almost six people per day die of illegal drug toxicity in BC. Victoria has consistently been among the top three townships in terms of the rate of overdose deaths.

Since 2016, there has been a steady scale-up of Naloxone distribution, opioid agonist therapy (OAT), and overdose prevention/supervised consumption services[2]. It has been suggested that without this scale up the death rate in the early period of the emergency would have been higher. However, given the ongoing high rate of deaths, more is needed.



On March 26th, 2020, BC's Ministry of Mental Health and Addictions with the BC Centre on Substance Use (BCCSU) introduced a clinical document entitled 'Risk Mitigation in the Context of Dual Public Health Emergencies' ('Risk Mitigation Guidance' or 'RMG'[3]) to support the prescribing of pharmaceutical alternatives to the toxic drug supply in order to reduce COVID-19 transmission and overdose among people who use substances.

In July 2020, the Victoria SAFER (Safer Alternatives for Emergency Response) Initiative was funded through Health Canada's Substance Use and Addictions Program (SUAP) to enhance access to safer supply in the capital region. SAFER is a flexible, community-based, safer supply project of AVI Health & Community Services (AVI), in partnership with SOLID Outreach. The goal of SAFER is to affirm the lives of people who use drugs (PWUD) by providing safer, pharmaceutical alternatives to the highly contaminated illicit drug supply. SAFER is grounded in a harm reduction approach, combined with access to prescription medications.

The purpose of this bulletin is to provide practical guidance from the Victoria SAFER Initiative that can assist other organizations in planning, developing and implementing safer supply programs. Below, we outline program development, including key principles and evidence underpinning SAFER, describe the SAFER model, and review initial evaluation indicators and outcomes.

Initial SAFER Program Delivery and Development

Given the urgency of dual public health emergencies, SAFER was initiated to rapidly implement services while also collecting information to inform the ongoing development of the program. To this end, SAFER immediately implemented the following key program activities:

1. A nurse was hired to work with people who use substances and living in encampments in Victoria city parks, to assess their risk for overdose. The target population were those accessing the toxic supply of illicit substances who were unhoused. This nurse connected eligible individuals with local addiction medicine physicians who were prescribing under the newly released provincial RMG.

2. At the same time, SAFER initiated a rapid community engagement process with service providers and other key stakeholders to collect feedback on how the program could best serve the community. An independent consultant was hired to seek the perspectives of community partners, service providers and engaged community members on how "pandemic prescribing" under the RMG had been working since being introduced in March 2020. A total of 13 interviews were conducted along with 20 survey responses. Participants were asked to identify key elements to improve access, and impact positive outcomes of initiatives developed to offer pharmaceutical alternatives to illicit drugs (the report detailing this process and findings is available upon request).
3. A project was initiated with SOLID Outreach and the Canadian Institute for Substance Use Research (CISUR) to specifically examine service users' perspectives on essential elements of safer supply programs. In this way, people with lived/living experience of illicit substance use were directly engaged in the ongoing development of SAFER (see description of service user design below and presentation available on YouTube[4])

Below is a brief synthesis of insights and challenges that were identified by the SAFER outreach team during the initial phase of consultations, program development and implementation.

RMG Framed as Withdrawal Management: PWUD and others indicated that RMG prescribing was often framed as withdrawal management by physicians. PWUD indicated that this approach fails to acknowledge that persons use different types of substances for a variety of reasons. When prescribers assume dosing should only be sufficient enough to reduce withdrawal symptoms, persons with lived experience indicate that care fails to address the needs/wants of people who use drugs. The importance of having a flexible approach to providing access to the right substances in the correct dosages was emphasized by community stakeholders including PWUD. Requirements of urine testing and being cut off of medications for failure to pick up were identified as barriers to continuing RMG prescriptions. PWUD also indicated that the RMG does not include substances that can be smoked, despite the majority of overdose deaths in BC being attributed to inhalation[5]. Further, prescribers raised ethical concerns about starting a new intervention with the knowledge that they may need to withdraw prescriptions should the RMG be retracted, as well as unintended harms of prescribing such as displacement or unintended use often referred to as diversion by prescribers.

Coupling Prescribing with COVID-19: RMG[3] coupled the prescribing of pharmaceutical alternatives with COVID -19. Eligibility criteria for RMG included active substance use, risk for overdose or other substance use related harms, and risk of COVID-19. The connection to COVID-19 gave some prescribers the impression that RMG applied only to patients with suspected or confirmed COVID-19, with the belief that it would likely be rescinded post-pandemic.

Lack of implementation guidance: RMG, as a provincial policy for prescribing, was not accompanied by adequate support and guidance for physicians to prescribe medications for the purpose of overdose risk reduction, nor guidance for programs wishing to implement and support these practices. Educational presentations and modules were created by the BCCSU post release. However, there was an absence of specific support and clarity re RMG from the BC College of Physicians and Surgeons regarding their position as a governing body.

Service User Design

Harm reduction principles explicitly foreground the leadership and engagement of PWUD in developing programs, services and policies. This is well aligned with health systems goals of patient-, client- or family-centred care to ensure effectiveness of services.

SAFER engaged with CISUR to train Community Researchers with lived or living experience from SOLID to initiate a service user design process. The team used a technique called Concept Mapping to capture

information on optimal methods to provide safer supply to a diverse group of service users. In Fall 2020, the SAFER Research and Evaluation team spoke with 63 persons, who identified as using illegal drugs, to engage in a series of focus groups and data analysis. The first round of focus groups included brainstorming with participants to answer a focus prompt: 'Safer Supply would work well if….' The team used the results to derive a set of 68 key statements. Focus group participants were then reconvened to sort the 68 statements into groups that were conceptually similar, providing the basis for a cluster analysis. They came together a third time to rate each statement on importance and feasibility. The resulting Concept Map describes an ideal model of safer supply from the perspectives of PWUD. The model consists of six clusters that speaks to important aspects of safer supply:

A. **Right Drugs in the Right Dose for Me:** Drugs that are safe and non-toxic and accessible legally and without criminalization. Having options and choices of drugs is critical to figuring out what works best for each person and ensuring that dosages are strong enough as well as available for both injecting and smoking.

B. **Being Able to Access Safe, Positive and Welcoming Spaces:** without fear of stigma, judgements, blame or being labelled with a disorder in order to get access. Having people who make you feel welcome and that you feel safe to talk to is critical, and it is especially important to have peers on the team. There should be physical spaces for smoking and injecting and access to mental health support if needed. Programs should not be short term.

C. **Safe Supply and other Services are Accessible to Me**: Safer supply should be easily accessible without having to jump through a lot of hoops. Safer supply shouldn't be limited to a seven-day script or require urine testing. Services like drug checking or access to housing and other supports should be available. Police should not be present.

D. **I am Treated with Respect:** Being treated with respect and deserving of care with an emphasis on developing trust in healthcare relationships. Safer supply initiatives should have people who know and understand what PWUD go through, are good at communicating and following through.

E. **I Can Easily Access my Safer Supply:** Caring prescribers who understand dope, who trust PWUD with a prescription, provide a personalized supply with carries (more than daily or weekly) along with medical care in a safe and therapeutic environment. Not getting cut off or having dosages dropped for missing days. Programs with peers who understand drugs with mobile and outreach options as well as consistent and stable medication delivery. Ensure care is available for both opioid and stimulant users.

F. **Helps Me Function and Improves my Quality of Life (as defined by the service user):** Not having to do daily witnessing or pickups is important to quality of life. Functionality would be improved by access to more than Suboxone, by having something that helps deal with chronic pain, and to replace stimulants. Functioning and quality of life would be improved by alternatives that get the monkey off your back, drugs that help you feel normal or allow you to function with access to other treatment options.

Professional Responsibilities and Ethical Analysis

Physicians in British Columbia are required to abide by professional standards of the College of Physicians and Surgeons of British Columbia as well as the Canadian Medical Association Code of Ethics and Professionalism.

The Canadian Medical Association Code of Ethics and Professionalism as well as the College of Physicians and Surgeon *Practice Standard on Access to Medical Care* point to a prohibition on discrimination of patients on any basis of identity, medical condition or complexity. As the College notes in its *Practice Standard: Access to Medical Care*: "Discrimination in the provision of medical services is prohibited in British Columbia under the BC Human Rights Code." They state further:

> The CMA *Code of Ethics and Professionalism* provides a similar prohibition against discrimination of patients on the grounds of age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status.

While physicians may refuse treatment for patients not requiring urgent care, this refusal should not be on the basis of complexity of care or medical condition as in the case of substance use disorders.

The College of Physicians and Surgeons of BC also lays out the professional responsibilities of physicians in relation to opioid prescribing including following guidance from the BC Centre on Substance Use in relation to the treatment of opioid use disorders.

Given concerns about the possibility that prescribing opioids, as an alternative to the toxic drug supply can further dependence, the BC Ministry of Mental Health and Addictions commissioned an ethical analysis of providing pharmaceutical alternatives to examine ethical obligations of healthcare providers in the context of high rates of overdose deaths (this report is available on request from the Ministry). In this analysis, the ethicist asserted:

> "A healthcare professional would have an ethical obligation to prescribe a medication that would allow the drug user to avoid having recourse to a toxic drug supply rather than the professional insisting on only prescribing on the condition of engaging in individualized medical treatment that extends beyond what the individual specifically requests."

They concluded that it is not ethically appropriate to approach prescribing with an assumption of diversion or other assumptions about patients in relation to medication management; doing so would constitute ethical judgement which is counter to professional ethics. The ethicist went further to suggest that if diversion did occur in the absence of witnessed administration it would reduce the reliance of other people who use drugs on a highly toxic market and realistically reduce their harms. Thus, they concluded that the benefits of providing pharmaceutical alternatives outweighs the harms and prescribing alternatives is not ethically objectionable in the context of reducing the harms of a toxic illicit drug supply. The ethicist stated that:

> "if these data support the conclusion that prescribing tablet injectable opioids would, on balance, reduce the risk of harm, then it would be ethically obligatory to engage in such prescribing even if death might occur on occasion. Failure to prescribe would be to ignore the fact that the likelihood of death or other adverse side effects would be reduced because the drugs that would be used would not have toxic adjuvants. Consequently failure to prescribe would be a violation of the fiduciary obligation of the professionals to act in the best interest of those with whom they interact—in this case people who use drugs —and for society not to institute an appropriate programme would be for society to fail in its obligation to provide appropriate health services."

Evaluation of Provincial RMG Guidance

Two different analyses of mortality among persons receiving pharmaceutical alternatives (RMG medications in BC and SAFER participants in Victoria) have indicated low rates of mortality. PharmaNet[7] and other Ministry of Health[8-10] data available through the BC COVID-19 Cohort[11] indicates an estimated 6,498 people were dispensed RMG prescriptions from March 27th 2020 to February 28, 2021. Of the 6,498 persons who were dispensed RMG medications from March 27, 2020 to February 28, 2021, 58% of persons received opioid medications, the most common being hydromorphone. Overall, among 6,498 persons who received RMG during the period, an estimated 82 persons died representing 13.2 deaths per 1000 person years.

The low number of deaths among people who received RMG prescriptions is consistent with findings presented by Dr. Aaron Shapiro (Associate Scientific Director, Provincial Toxicology Centre, BCCDC) to the Pharmaceutical Alternatives Guidance Committee Evidence Review Meeting on October 22, 220. Dr. Shapiro indicated that from July to September, 2020, hydromorphone was detected in 9 of 340 deaths attributed to illicit drug toxicity (3%) which is similar to rates from 2018 and 2019.

SAFER Initiative

In September 2020, following 2 months of initial service provision with one outreach nurse, SAFER launched a multidisciplinary outreach team of nurses, outreach workers with lived or living experience and systems

Maximum Dose Ranges: Expansion of maximum dose ranges that better reflect the growing opioid tolerances of people accessing a volatile and increasingly contaminated illegal drug supply.

Expansion of Opioid Options: Oxycodone immediate-release was added as an alternative to hydromorphone. Participants reported preference for oxycodone and having the agency to choose is consistent with core harm reduction principles and findings of the service user design. Through consultation with PWUD, it was suggested that oxycodone was more easily smoked than hydromorphone. The rationale for offering a substance that can be used in the preferred route of consumption includes the hope that this will prevent transitions to intravenous use, diversion of medications, and continued reliance on the illegal drug supply. Oxycodone was already covered under PharmaCare, ensuring participants would not incur additional costs associated with their medications.

Opioid Agonist Therapy: Another important differentiation between RMG prescribing and SAFER prescribing practices was the language used to describe the role of OAT. While the RMG document never directly required OAT as a condition for pharmaceutical alternatives, many community prescribers interpreted the guidance to require OAT. The SAFER team heard from participants who felt coerced to accept OAT in order to access pharmaceutical alternatives. Harm reduction principles emphasize that services should be evidence-based and non-coercive. While it is important that participants are offered OAT, patients should not be refused RMG if they decline OAT.

Requirements of Addiction Medicine: Despite intention to foreground SAFER in harm reduction principles, SAFER prescribing practices still adhere to a number of addiction medicine constructs, including frequent urine drug screening (UDS), short prescription durations (average 21-28 day prescriptions) and a denial of carries (all diversion mitigation efforts). Thus, the project exists at the intersection of addiction medicine and harm reduction. This compromise was important to the physician team who are under scrutiny by the broader community of prescribers and their regulatory college. We acknowledge these tensions and seek to navigate them within a unique interdisciplinary team that also includes outreach workers with lived or living experience.

navigators. In January 2021, the team collaborated on a working document to speak to the top 10 things they had learned and wanted people to know about safer supply. They submitted their thoughts in point form emails which were collaboratively compiled into a 'top ten' document. The SAFER Top Ten[12] integrates learning from stakeholder consultations, service user design and preliminary evaluation findings.

Based on the currently available information, guidance, and evidence, the SAFER clinical team developed specific prescribing guidelines, based on the RMG, to address the program's mandate to develop a flexible, harm reduction model for pharmaceutical alternatives. In Fall 2020, SAFER team (5 physicians, a clinical lead, project manager, and outreach team) collaborated to develop and refine clinical workflows and prescribing practices. We outline modifications that were made in reference to RMG based on PWUD and clinician feedback:

Part of SAFER's mandate is to promote knowledge exchange with the intention to broaden accessibility to pharmaceutical alternatives across the province. As such, SAFER's clinical prescribing guidance documents are accessible and available upon request.

Preliminary Indicators and Outcomes From Service Provision

As of April 2021, SAFER was supporting 72 active participants with majority identifying as male (n=53). Forty-six participants were receiving prescriptions of opioids only (64%), 5 participants received stimulants only (7%), and 21 participants received a combination of opioids and stimulants (29%).

From September 2020 to April 2021, SAFER discharged 20 people for a variety of reasons including: unable to locate (4); moved away (3); incarcerated (2); transition to new primary care provider (7); housed with new primary care provider on-site (1); mental health barriers to engagement (1), and no longer wants to engage (2).

The team had also made outreach connections with an additional 82 persons who were not brought on as participants but who were referred to another primary care provider for safer supply or other health care, received wound care, or brief support and information.

In addition to safer supply and primary healthcare, SAFER provides practical supports to participants and as of April 2021, was engaging with over 90% of active participants to provide assistance with supports such as obtaining a birth certificate (34 applications), accessing income (25 applications for basic and PWD), filling out housing applications (28 applications), accessing legal support (13 people), and other referrals and social supports (eg. other outreach teams, taxes, recreation passes, detox, supportive recovery, other harm reduction services, pregnancy-related supports, and supports by and for Indigenous individuals.

SAFER's outreach team notes observations and collects feedback from participants on an ongoing basis.. The following is a summary, as of April 1, 2021, of indicators used to evaluate clinical impacts of receiving safe

Decreased cravings: 12 men; 5 women. Participant stated, "Even if I have side, I don't have the urge and can wait to use, when I take my meds."

Decreased withdrawal symptoms: 11 men; 5 women. Participant stated "I don't get as dope sick anymore", thanked team for support.

Safer use practices: 19 men; 3 women. Participant stated that since starting [meds] that his route of use has decreased in IV injection and more inhalation which was one of his identified goals.

Reduced use of illegal substances: 35 men; 6 women. Participant states that she did not need to use meth yesterday after being on dexedrine even though she had some on hand. Client reports a decrease of fentanyl use by 1-2 points since starting OAT and [safe supply meds].

supply prescriptions and support from SAFER as reported by approximately 45 SAFER participants and noted by outreach staff in the chart. UVIC ethical approval was obtained for a chart review.

Reduced Harms of Substance Use

Healed wounds: 7 men; 0 women. Participant reports having fewer abscesses since starting safe supply.

Improved mental health: 10 men; 4 women. For example, "I talk to people in general more since SAFER because I feel less sick and stressed out!"

Increased connection to healthcare: 14 men; 4 women

Better Health Maintenance: Despite SAFER not being a primary care, case management service specifically, the team has been successful in supporting participants to engage in better health maintenance. SAFER has supported:

- 14 unique participants to complete routine blood work
- 10 participants in completing COVID19 swabs
- 3 pregnant participants in accessing prenatal care
- 3 participants in accessing managed alcohol programming

Less reliance on street economy: 11 men; 6 women. For example, "Slowed down with crime to get dope!"

Improved overall function: 6 men; 3 women. Stated SAFER helps participant to function better and perform daily tasks.

Connecting to social supports like housing, obtaining personal identification, income, etc: 14 men; 5 women.

- "I no longer feel like it's me versus the system. I feel like we're working together. I wish SAFER was given more power."
- "A lot of services I didn't even know existed were brought right to my door by SAFER!"
- Staff reports progressive benefits from stimulant safe supply. Not requesting an increase of stimulant medications and states has been helpful when unable to acquire street stimulants.

Important indicators of success include reduction of a range of harms such as decreased cravings, withdrawal, safer use practices and less use of contaminated illegal drugs. Program participants were asked by the team what, if any impact safe supply prescribing had on their lives over a 3-4 week timeframe. Fifty-four percent (32 men; 7 women) of SAFER participants reported that they had been able to reduce potential harms from substance use.

Social or Health Outcomes

53% (29 men; 9 women) of SAFER participants reported at least one positive social or health outcome enabled by SAFER support. Examples of this included:

Urine Drug Screens: A point-in-time chart review revealed further encouraging outcomes demonstrating the potential high efficacy of a flexible, harm reduction model for delivering pharmaceutical alternatives. Despite

the project's intentions to not rely exclusively on traditional addiction medicine metrics for success, data related to urine drug screening, engagement, and follow-ups are recorded.

While a urine drug screen is a poor stand-alone marker for success and inconsistent with a harm reduction model, a urine drug screen that indicates a participant is not actually taking their prescribed pharmaceutical alternatives is an indicator that the medications are not meeting the needs of the participant. In instances where participants are unable/unwilling to provide a urine drug screen, the prescribed dose is reduced by 50% rather than being outright discontinued. This is still paternalistic and problematic in the sense that it is punitive in nature.

A full evaluation of SAFER is currently being conducted by the CISUR Co/Lab team.

Key Challenges

The Victoria SAFER Initiative experiences with RMG and developing clinical guidelines and practices to meet the needs of PWUD in the Victoria region highlights some key challenges related to prescriber-based models of safer supply. These include concerns related to diversion/displacement, the available supply of substances, and the tensions between harm reduction and addiction medicine approaches.

Unintended use or displacement of prescribed substances is a contentious topic amidst the rollout of RMG and pharmaceutical alternatives. From a community standpoint, and the above mentioned ethics analysis, displacement of pharmaceutical alternatives poses the potential to reduce the likelihood of an individual accessing the toxic and volatile illegal drug supply. Available population level data reported above from the provincial RMG evaluation indicates low mortality rates. In community, PWUDs look out for one another, and that often involves splitting or sharing of prescribed substances[13] as part of harm reduction approaches to a safer supply[14]. Unfortunately, there is little medical support, or clinical guidance for prescribers if they become aware a patient is diverting medications and continuing to provide care informed by harm reduction. There would be significant concern by the prescriber that if they maintained a prescription that was being used in ways that are unintended, these medications could cause harm to those obtaining them. This is the tension point between addiction medicine and harm reduction that the SAFER team navigates together.

As previously discussed, there are a number of recommended addiction medicine strategies embedded within the SAFER clinical prescriber guidance documents, including UDS, daily dispensing, and frequent follow-ups. The team acknowledges that diversion typically indicates the medications being prescribed are not the right medications or right doses for the participant. When someone is known to be displacing their medications, punitive measures are contraindicated as that can drive increased risk of overdose and other harms of drug use. Our approach is to connect with that participant before making decisions about their prescription. Was it a one time occurrence, born out of need? Are there better options for this participant? Do we have a contingency plan to support this individual, as opposed to cutting them off their medications and potentially increasing their overdose risk?

With regard to opioid use, SAFER acknowledges the need for broader access to more potent and effective pharmaceutical alternatives. While many are being served through community-based prescribing of oxycodone and hydromorphone, others continue to report significant street fentanyl use, while being at the upper limits of SAFER prescriber guidance. For this reason, SAFER is adding to our outreach service model to include a physical site where participants who are not experiencing positive impacts from community-based prescribing will be able to access fentanyl-based programming. This will include the novel provision of prescribed fentanyl medications in transdermal patch, tablet and liquid formulations to address the unique needs of SAFER participants. Having more options is a displacement prevention practice. Rather than deeming a participant a 'poor fit' for a program, prescribers and teams should be striving to develop a continuum of options within their services rather than hoping for a one-size-fits all approach. As this work is undertaken, we continue to reflect on the model developed by service users and the SAFER Top 10 to enhance the program.

Conclusion

The Victoria SAFER Initiative launched during the context of the COVID-19 pandemic and the introduction of the BC provincial RMG was informed by deliberate community engagement and service user design. Based on community engagement, an ideal model of safer supply is one that functions within the context of a decriminalized, demedicalized supply.

SAFER strives to provide accessible peer support, primary care and community supports rooted in harm reduction. Person-centered, low barrier supports that encourage relationship-building and accessibility for individuals from diverse populations such as people who use drugs, women, sex workers, Indigenous people, trans and Two Spirit people are critical. People with lived/living experience must be well-supported to build their skills and take the lead in all elements of design and delivery of harm reduction healthcare models where people can have clear, honest communication with their care providers.

While SAFER has not fully met all of the elements of an ideal safer supply model as defined by PWUDs and other key stakeholders, the program is evolving and offering a range of drugs and dosages as well as inclusion of a variety of health and social services such as primary care and access to housing and income supports. Preliminary program data has confirmed that SAFER reduces the harms of the contaminated illegal drug supply and that participants are experiencing positive impacts to their physical and mental health.

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This brief was created by the **Co/Lab: A collaborative community laboratory on substance use and harm reduction** at the Canadian Institute for Substance Use Research as part of a series of evidence briefs supporting safe consumption sites and other harm reduction efforts in Canada. Co-Lab is funded by Health Canada's Substance Use and Addictions Program.

The views expressed in this brief are solely those of the authors.

July 2021

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Suggested Citation

Ranger, C., Hobbs, H., Cameron, F., Stuart, H., McCall, J. Sullivan, G., Urbanoski, K., Slaunwhite, A. & Pauly, B. (2021). "Co/Lab Practice Brief: Implementing the Victoria SAFER Initiative." Canadian Institute for Substance Use Research, University of Victoria, Victoria, Canada.