BC Coroners Service Death Review Panel: A Review of Illicit Drug Overdoses

May 7, 2018

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Overview

- **Background on the Review Panel's Death Review**

- **Provide an overview of:**
  - **The Review Panel's findings comparative to Alberta surveillance**
  - **The Review Panel's identified key areas to reduce illicit drug overdose deaths**
  - **The Review Panel's recommendations and identified priority actions**

Background

- On October 11, 2017, the British Columbia Coroners Service (BCCS) held a death review panel on illicit drug overdose deaths

- Panel consisted of professionals with expertise in:
  - public health, health services, substance use, mental health, aboriginal health, education, income assistance, child welfare, regulatory colleges, corrections and policing

- Method:
  - General statistical information of 1,854 overdose deaths between January 1, 2016 and July 31, 2017 was collected
  - A more detailed comparative review of 615 deaths over two time periods a year apart from one another was also conducted

Review Findings: Decedent Information

	BC	Alberta
Sex	81% male	74% male
Age	30-59	25-55
Indigenous Persons	10%	12%
Population Centres (large urban cores[1])	67%	68%
Location of Death	58% at a private residence	61% at home address
Frequency of Use	80% were those with a regular pattern of use	?
Use in Presence of Others (using alone)	57%	?

[1] Cities with more than 100,000 residents

Review Findings: Toxicology

	BC		Alberta	
	2016	2017	2016	2017
Fentanyl Presence	67%	81%	64%	76%
Polysubstance Use	81%	79%	57% of fentanyl deaths	78% of fentanyl deaths
Suboxone Presence	0%		?	
Methadone Presence	5% (almost all had evidence of polysubstance use)		?	

Review Findings: Contacts with Supports

Health Services:

	BC (12 months prior)	Alberta (30 days prior)	
		Fentanyl deaths	Other opioid deaths
ED Visit	55%	17%	7%
Hospital Admission	28%	?	?
Physician Visit	76%	46%[1]	71%[1]

[1] All health visits outside of hospitals and ambulatory care facilities

BC Corrections:

- **66% of decedents had been involved with BC Corrections. Of those,**
  - 10% died of an overdose within 30 days of release
  - 36% died within one year
  - 44% died within two years
  - 20% had participated in OAT at some point during their custody
- **No corrections specific data in Alberta**

Review Findings: Contact with Supports (cont'd)

- **BC rehabilitation and treatment programs:**
  - **Varying programs were accessed by some decedents**
    - Many experienced relapse following treatment
    - Following detox/abstinence, high risk of fatal overdose if relapse occurs
    - Following short-term OAT, a high percentage of individuals will relapse even when structured evidence-based counselling services are offered
  - **No dedicated regulation specific to treatment facilities; no evidence-based standards**
    - Alberta has also recognized a lack of regulation of treatment facilities as being an issue (Recommendation 25)

Summary of Findings

- A substantial number of overdose deaths occurred among:
  - persons with recent health care and/or recent or previous BC Corrections involvement;
  - persons who used substances regularly;
  - persons who were using alone; and
  - persons who had sought treatment services in the past and experienced relapse.
- Majority of overdose deaths occur in private residences
- Fentanyl in overdose deaths continues to rise
- OAT are an effective component of an OUD treatment continuum
- There are no provincial regulations for evidence-based standards for addiction treatment

Identified Key Areas to Reduce Illicit Drug Overdose Deaths

1. Provincial regulation for treatment and recovery programs to ensure that:
   a. Evidence-based, quality care is provided, and
   b. Outcomes are closely monitored and evaluated.
2. Expand access to evidence-based addiction care, including:
   a. OAT,
   b. iOAT, and
   c. Recovery supports.
3. Improve safer drug-use through the creation of accessible provincial drug checking services

Recommendations

Recommendation 1: Ensure Accountability for the Substance Use System of Care

Recommendation 2: Expand Opioid Agonist Treatment and Assessment of Substance Use Disorders

Recommendation 3: Expand Drug Use Safety Options

Recommendations: Priority Actions

1. **Ensure Accountability for the Substance Use System of Care priority actions:**
   - Establish leadership groups
   - Develop treatment standards (including evaluation and monitoring)
   - Establish a provincial registry of licensed, regulated addiction programs and facilities
   - Consult and engage with persons with lived/living experience on an ongoing basis
2. **Expand Opioid Agonist Treatment and Assessment of Substance Use Disorders priority actions:**
   - Support physicians to assess patients for substance use disorders, and develop and implement referral mechanisms
   - Invest in health care training programs and support services to ensure availability of OAT and iOAT

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Recommendations: Priority Actions (cont'd)

3. **Expand Drug Use Safety priority actions:**
   - **Ensure those released from incarceration or on community supervision:**
     - have access to naloxone kits,
     - are aware of how to access drug checking services, and
     - are linked to addiction services in their community, including OAT.
   - **Establish and evaluate community based drug checking services**
   - **Ensure point of care access to PharmaNet medication information for all prescribers and dispensers of opioid medications**
   - **Ensure access to PharmaNet medication information for all regulatory colleges**