
EMERGENCY


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Disclosure Statement

Current grant funding:

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE
The Science Of Drug Abuse & Addiction

CDC

National Drug Abuse Treatment
Clinical Trials Network

Aetna

Provided funding for filming & production of videos displayed on our interactive web portal

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

The 24/7/365-day Option

To Fight the Opioid Crisis

Faces of Addiction

Number of opioid-related deaths in 2017
by province or territory

Everyday, more than 11 people in Canada die from opioids

WHITEHORSE

YELLOWKNIFE

Andrew Gallager
1987-2016
British Columbia
Accidental Overdose

Steven Howe
1982-2015
Alberta
Fentanyl related OD

Alexandria Sanderson
1995-2017
Manitoba
Fentanyl Overdose

Stephanie Vermiere
1988-2017
Manitoba
Fentanyl poisoning

EDMONTON

SASK

WHISTLER

BANFF

CALGARY

VANCOUVER

VICTORIA

REGINA

WINNIPEG

ST. JOHN'S

CAPE BRETON

CHARLOTTETOWN

FREDERICTON

HALIFAX

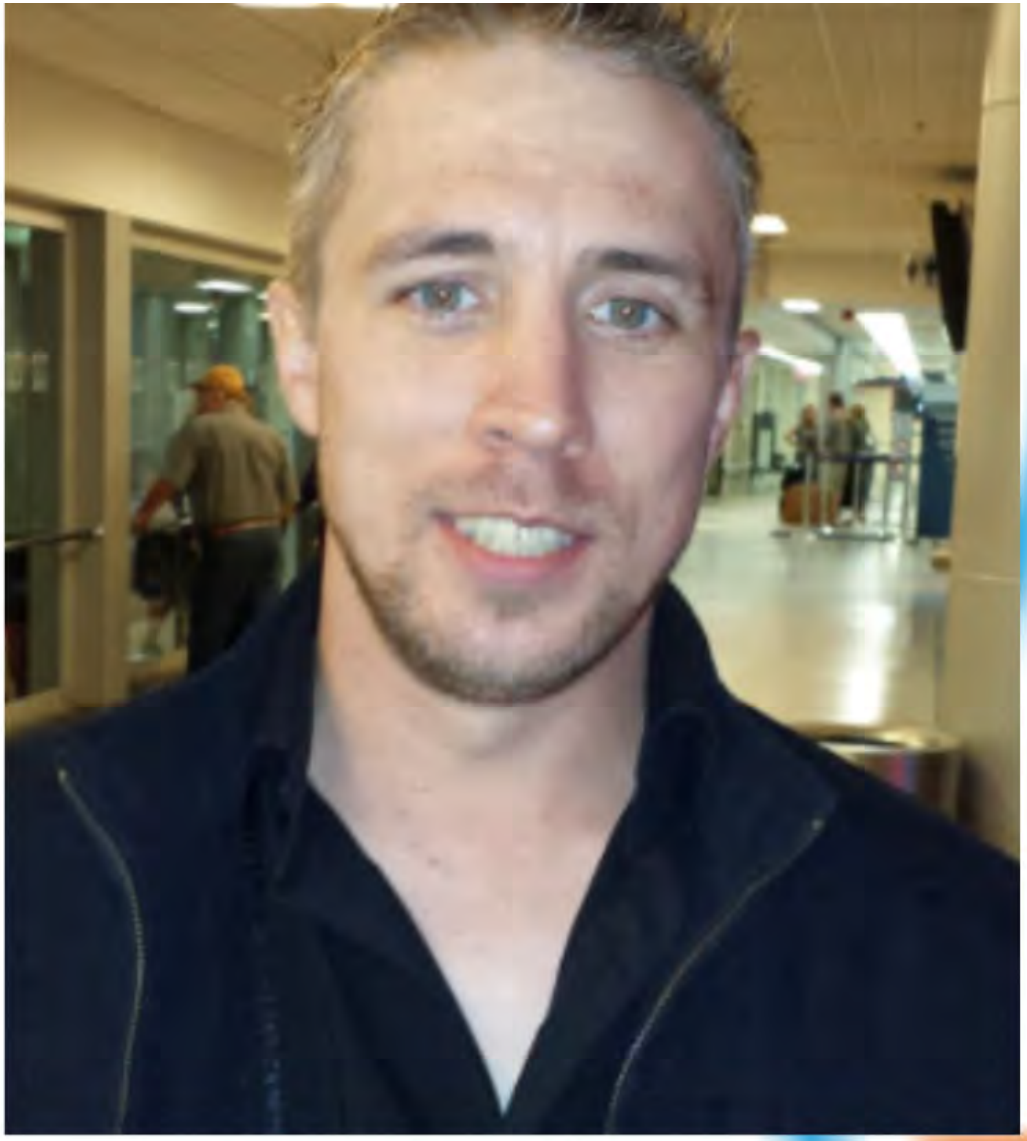
QUEBEC CITY

MONTREAL

OTTAWA

TORONTO

NIAGARA FALLS



Andrew Gallager
1987-2016
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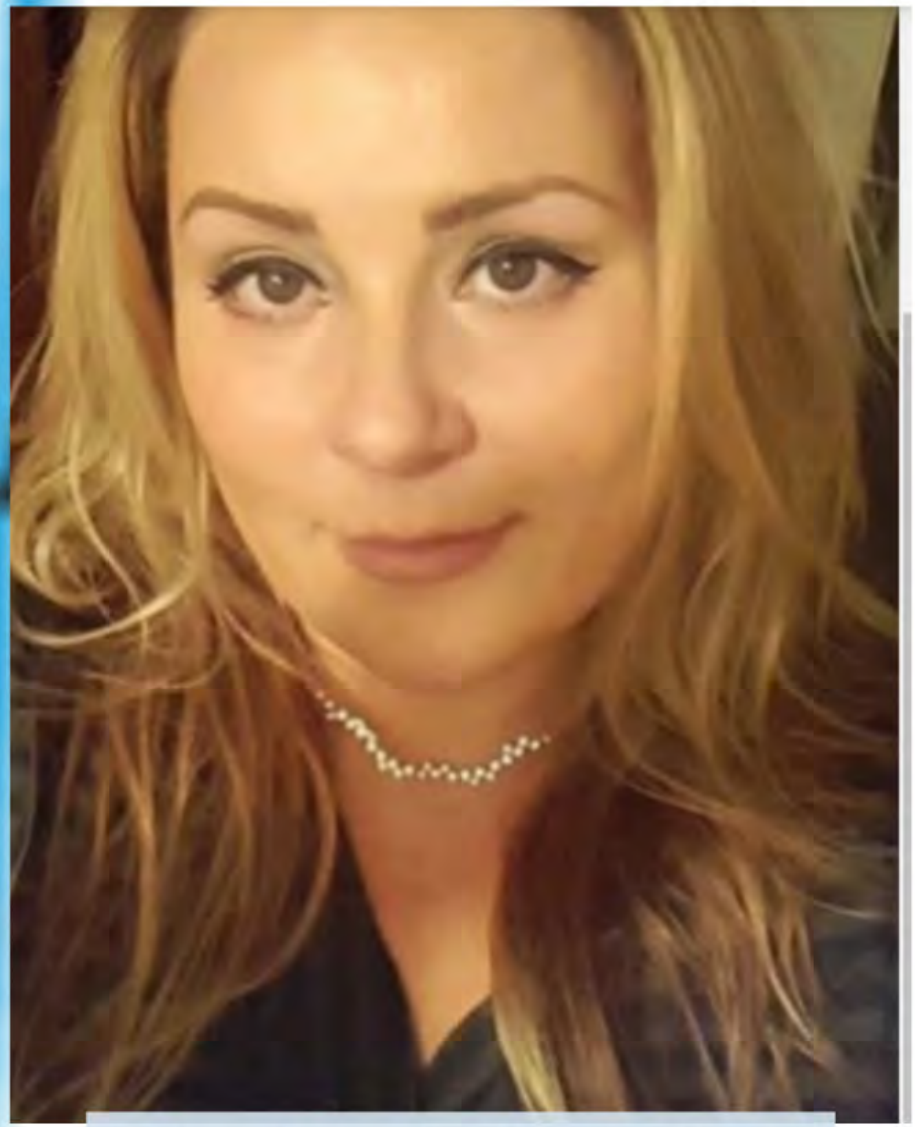
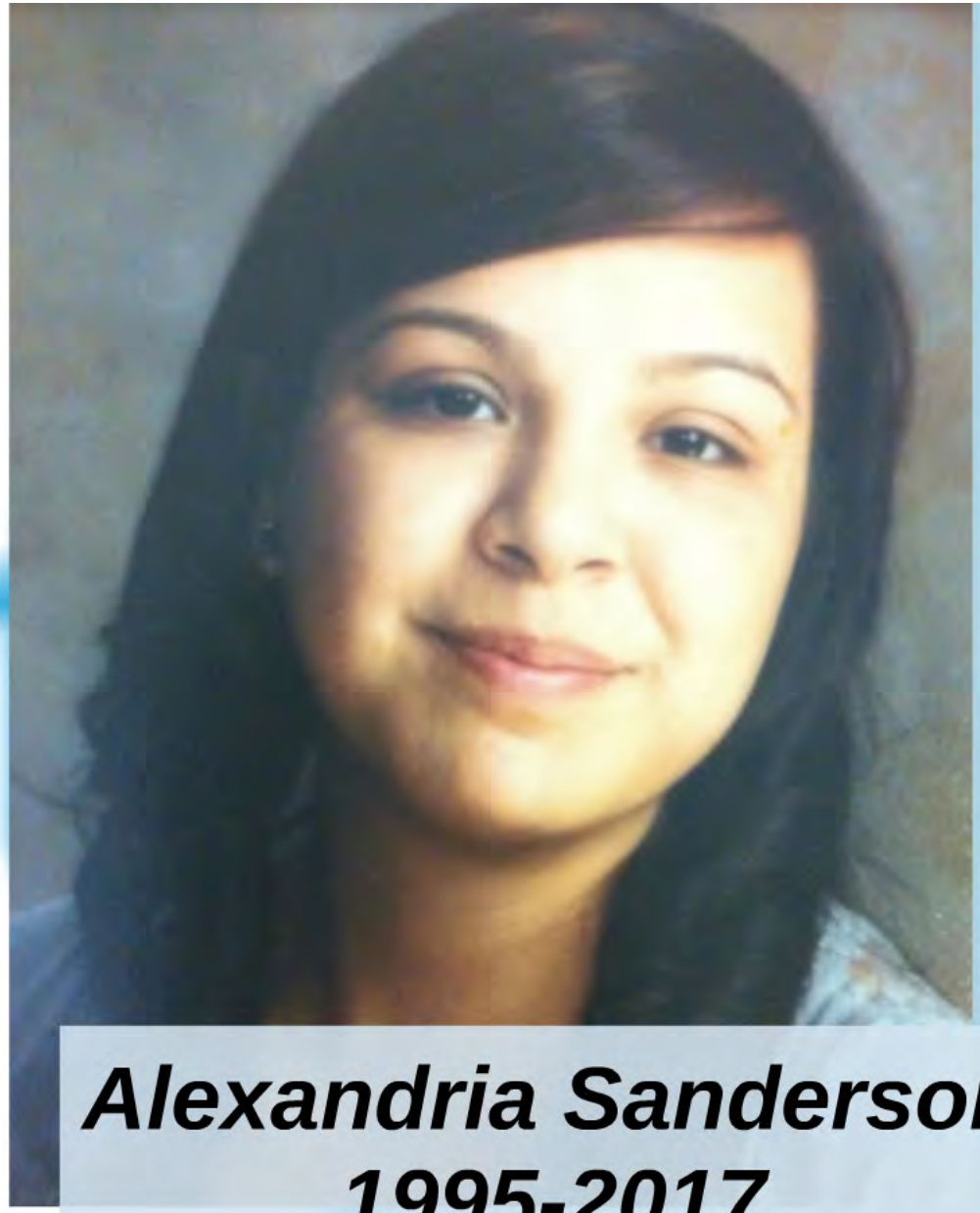
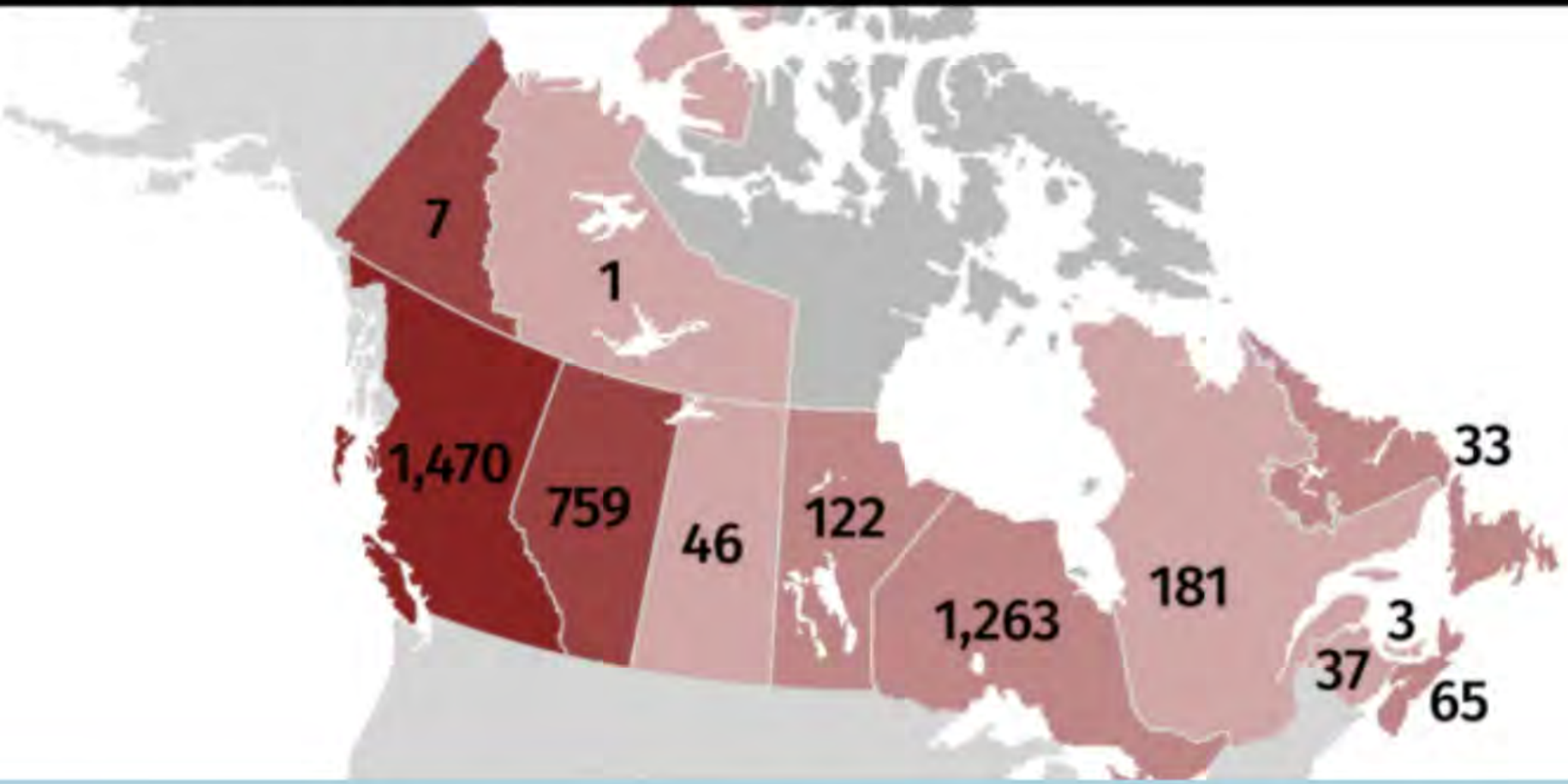


Stephanie Vermiere
1988-2017
Manitoba
Fentanyl posioning



Alexandria Sanderson
1995-2017
Manitoba
Fentanyl Overdose

Number of opioid-related deaths in 2017
by province or territory

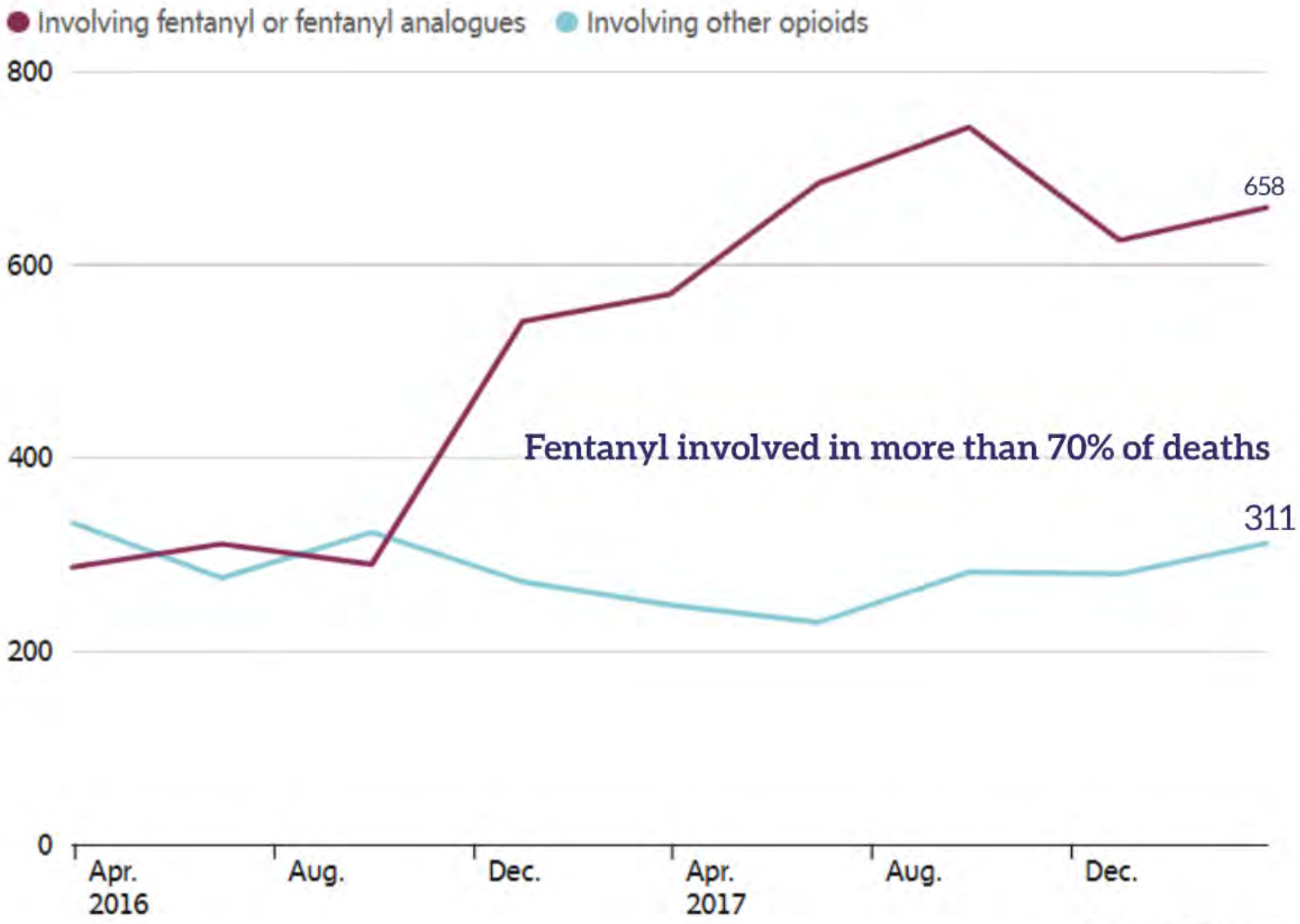


Everyday, more than 11 people in Canada die from opioids

8,000 opioid-related deaths (1/ 2016 -3/ 2018)

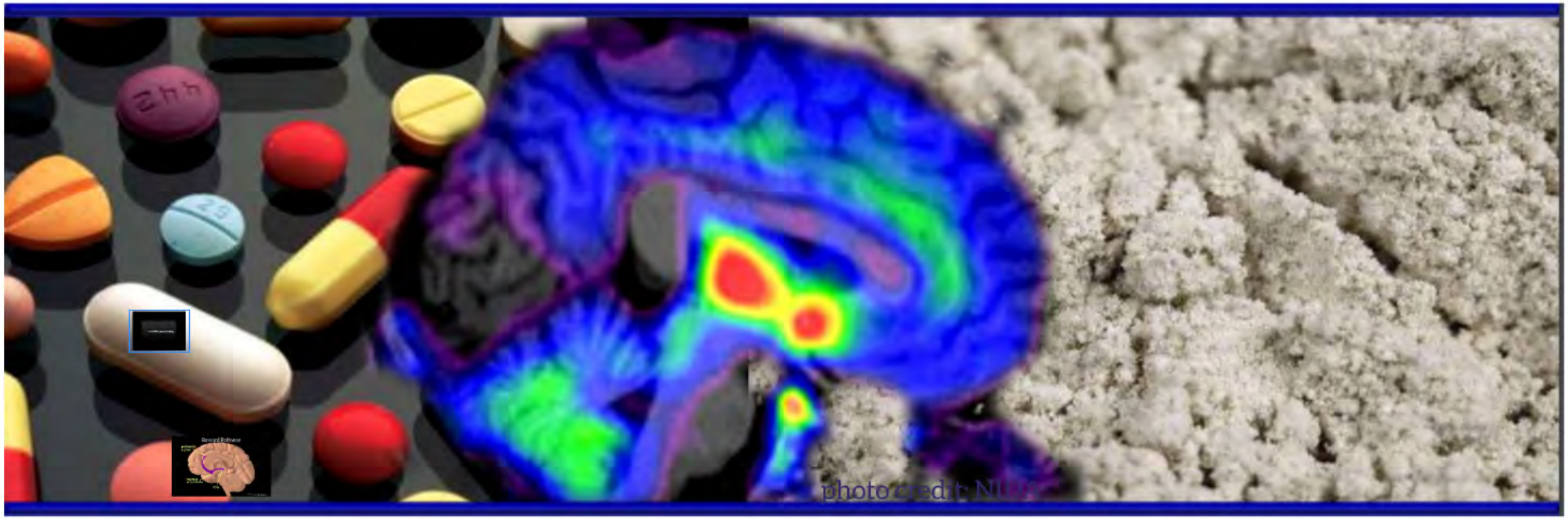
Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: Apparent opioid-related deaths in Canada (January 2016 to March 2018) Web-based Report. Ottawa: Public Health Agency of Canada; September 2018.

Number of Opioid-Related Deaths

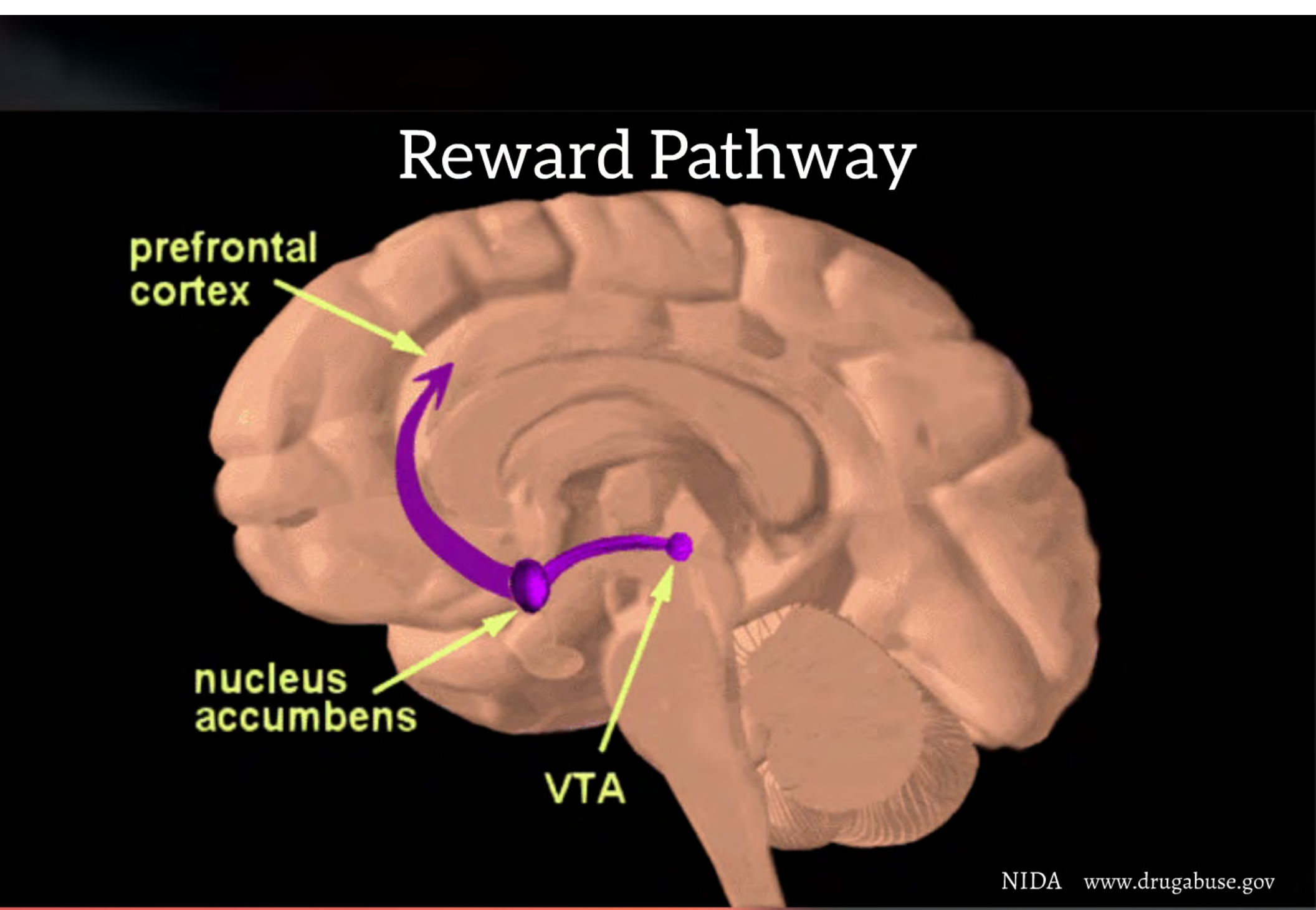


Source: Public Health Agency of Canada

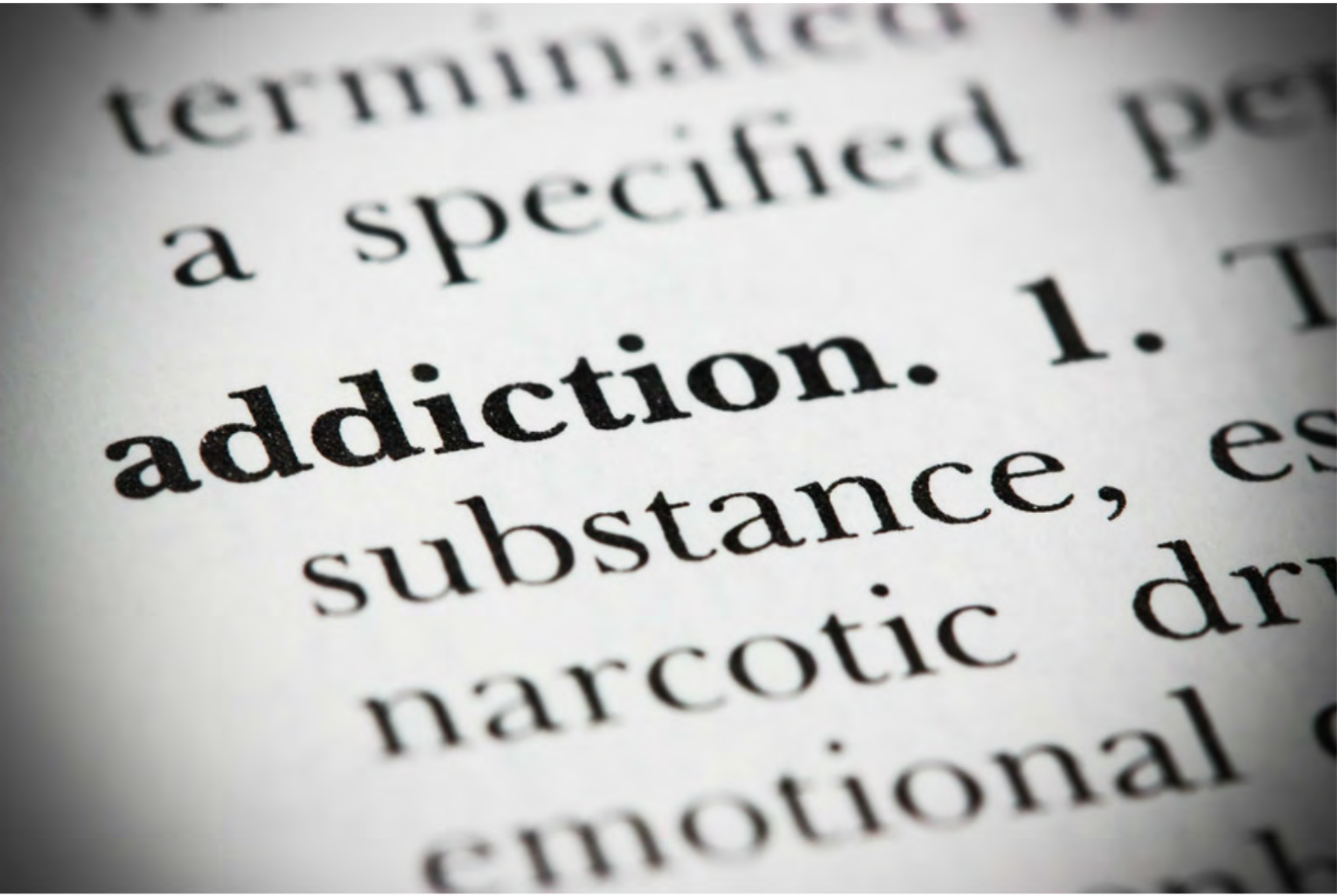
The Science of Addiction



Reward Pathway

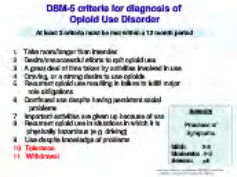



It is NOT a moral failing


terminated
a specified
addiction. 1.
substance,
narcotic
emotional

Chronic Pain

Opioid Use Disorder


DSM-5 criteria for diagnosis of Opioid Use Disorder

At least 2 criteria need be met within a 12 month period

1. Takes more/longer than intended
2. Desire/unsuccessful efforts to quit opioid use
3. A great deal of time taken by activities involved in use
4. Craving, or a strong desire to use opioids
5. Recurrent opioid use resulting in failure to fulfill major role obligations
6. Continued use despite having persistent social problems
7. Important activities are given up because of use
8. Recurrent opioid use in situations in which it is physically hazardous (e.g. driving)
9. Use despite knowledge of problems
10. Tolerance
11. Withdrawal

Severity: Presence of symptoms

Mild: 2-3
Moderate: 4-5
Severe: ≥6

Experimental Use

- Combination of behavioral, environmental and biological factors increase vulnerability
- Genetic risk factors account for 50% of the likelihood that an individual will develop addiction

DSM-5 criteria for diagnosis of Opioid Use Disorder

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11. Withdrawal

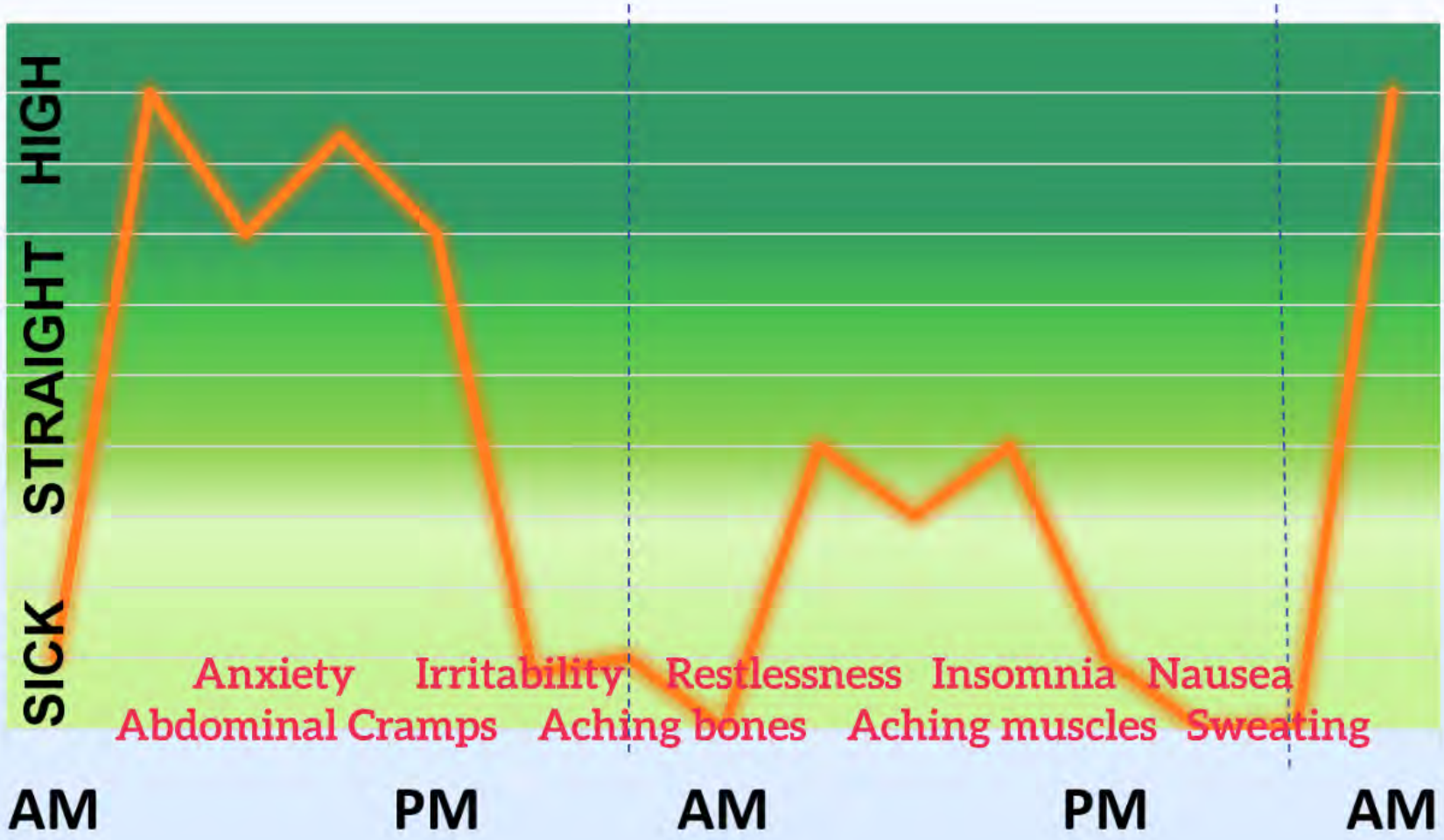
Severity

Presence of Symptoms

Mild: 2-3
Moderate: 4-5
Severe: ≥6

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.).

What does it feel like to have opioid use disorder?



From "Narcotic Blockade" by V.P. Dole, M.E. Nyswander and M.J. Krock, 1966, Archives of Internal Med

Effective Treatments for Opioid Use Disorders

What is NOT considered evidence based treatment?

Detoxification only

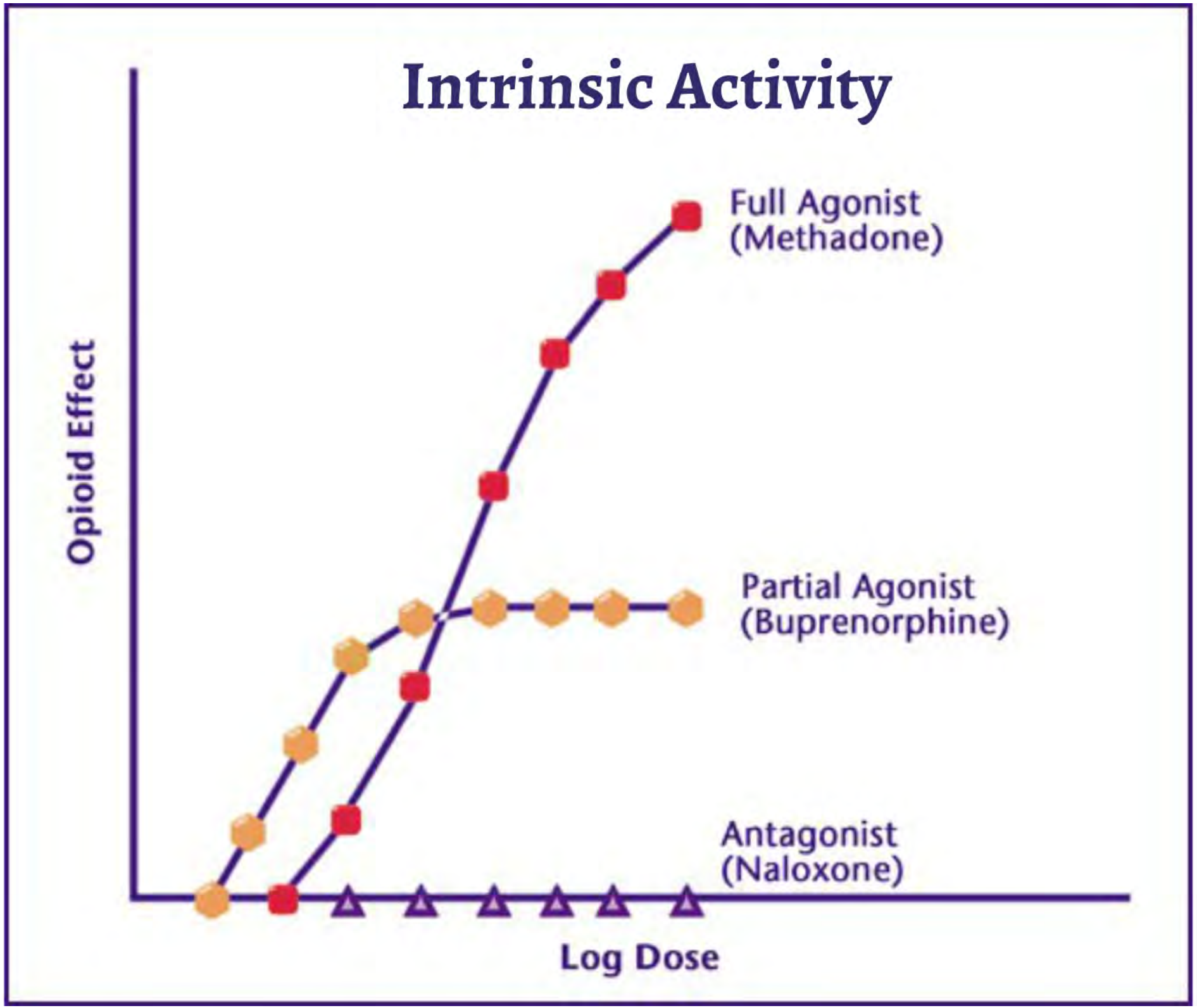
Abstinence-oriented therapy

Mutual support programs

Naloxone (Narcan)

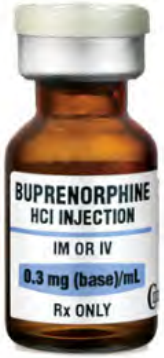
Medication for **Addiction Treatment**

Options for ED providers:


Intrinsic Activity
Opioid Effect
Full Agonist
(Methadone)
Partial Agonist
(Buprenorphine)
Antagonist
(Naloxone)
Log Dose

Buprenorphine

- Semisynthetic, highly lipophilic thebaine derivative
- 25 to 50 times more potent than morphine
- Partial μ-agonist
- Often combined with naloxone

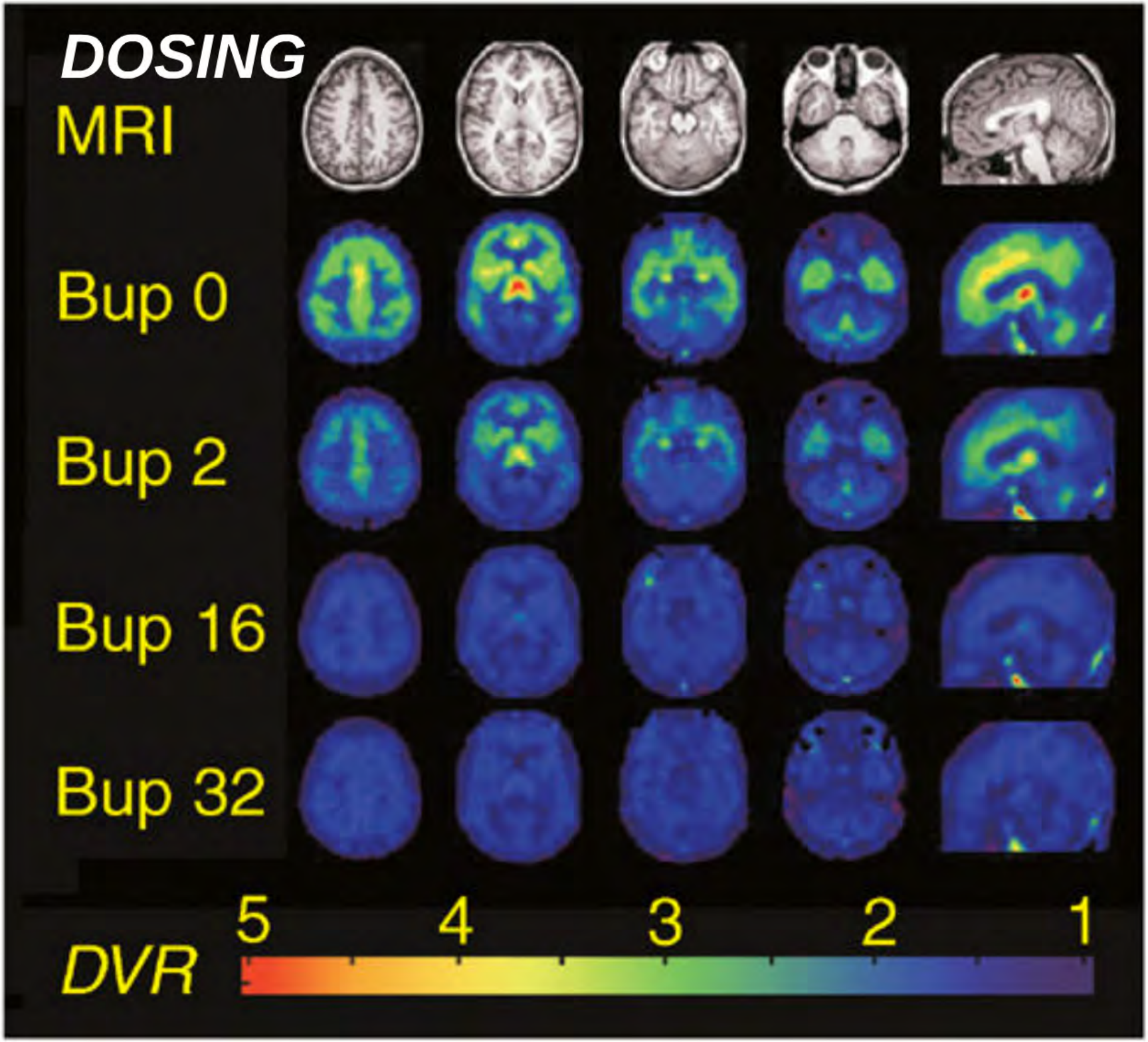


Braeburn Pharmaceuticals And Camurus Announce Positive Top-Line Phase 3 Results For Long-Acting Buprenorphine For Treatment Of Opioid Addiction

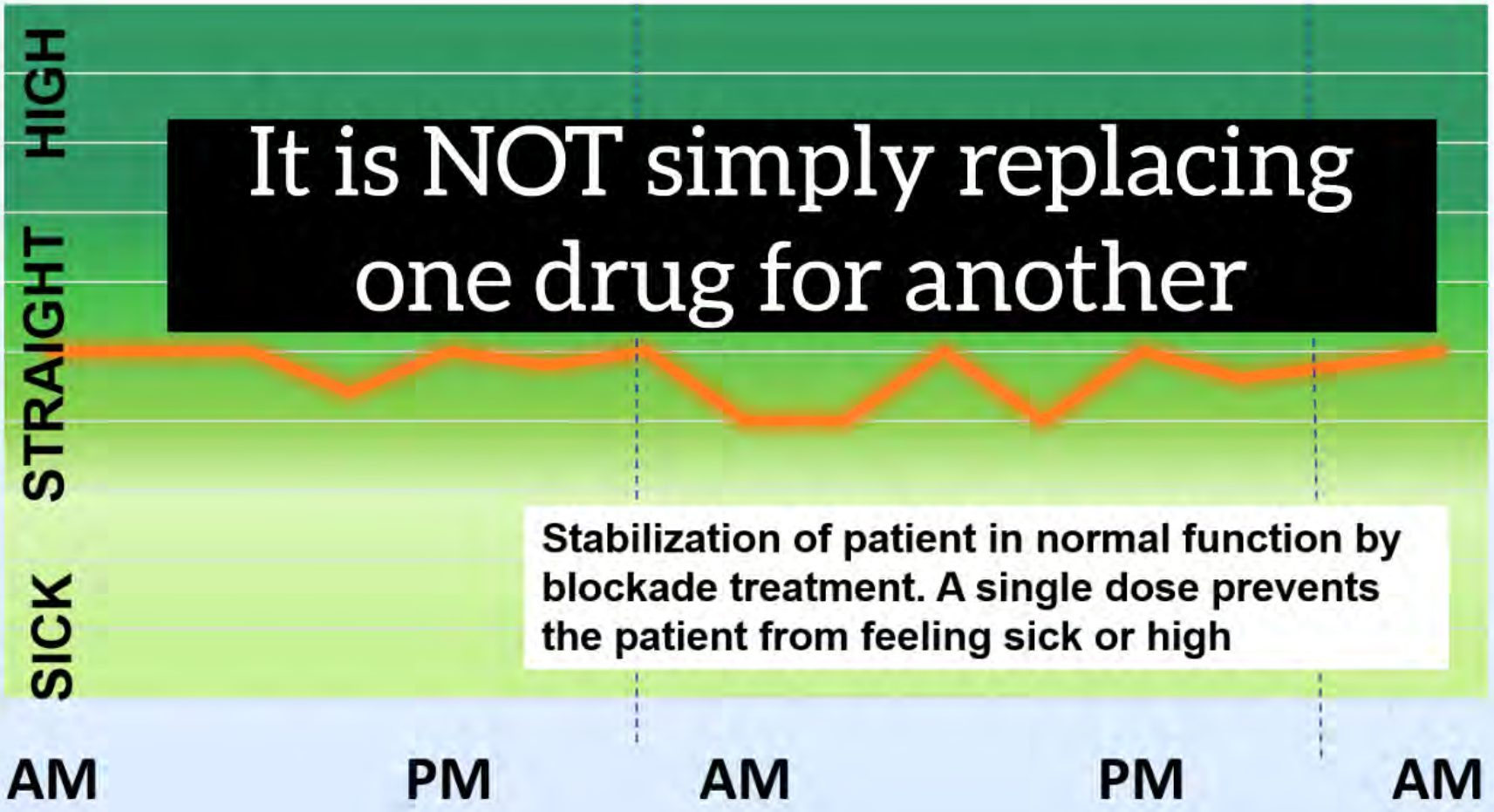
TOPICS: Clinical Trials For Opioid Addiction Medical News

Formulations

Sublocade™
(buprenorphine extended-release) injection for subcutaneous use
100mg·300mg

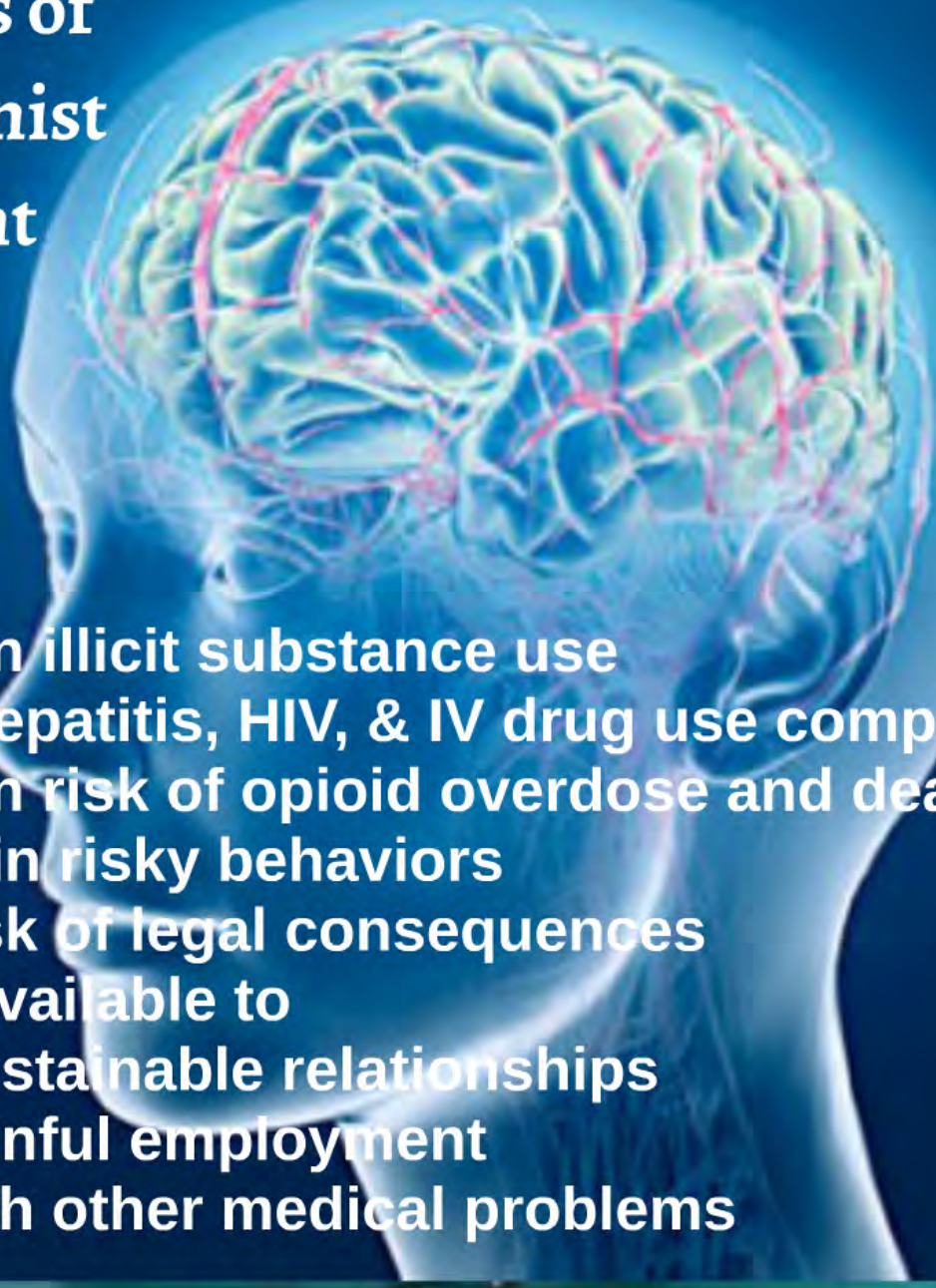

DOSING
MRI
Bup 0
Bup 2
Bup 16
Bup 32
DVR
5
4
3
2
1

What does it feel like when taking opioid agonist treatment?



Adapted from "Narcotic Blockade" by V.P. Dole, M.E. Nyswander and M.J. Krock, 1966, Archives of Internal Med

Advantages of Opioid Agonist Treatment



- Reduction in illicit substance use
- Less viral hepatitis, HIV, & IV drug use complications
- Reduction in risk of opioid overdose and death
- Reduction in risky behaviors
- Reduced risk of legal consequences
- More time available to
    - -Have sustainable relationships
    - -Find gainful employment
    - -Deal with other medical problems

RESEARCH

JAMA Psychiatry | Original Investigation

2017

Effectiveness of Injectable Extended-Release Naltrexone vs Daily Buprenorphine-Naloxone for Opioid Dependence
A Randomized Clinical Noninferiority Trial

Lars Tanum, MD, DMSci; Kristin Klemmetsby Solli, MSc; Zill-e-Huma Latif, MD; Jūratė Saltytė Benth, PhD; Arild Opheim, MSc; Kamni Sharma-Haase, MD; Peter Krajci, MD, PhD; Nikolaj Kunøe, MSc, PhD

Supplemental content
CME Quiz at jamanetwork.com/learning and CME Questions page 1284

IMPORTANCE To date, extended-release naltrexone hydrochloride has not previously been compared directly with opioid medication treatment (OMT), currently the most commonly prescribed treatment for opioid dependence.

OBJECTIVE To determine whether treatment with extended-release naltrexone will be as effective as daily buprenorphine hydrochloride with naloxone hydrochloride in maintaining abstinence from heroin and other illicit substances in newly detoxified individuals.

DESIGN, SETTING AND PARTICIPANTS A 12-week, multicenter, outpatient, open-label randomized clinical trial was conducted at 5 urban addiction clinics in Norway between November 1, 2012, and December 23, 2015; the last follow-up was performed on October 23, 2015. A total of 232 adult opioid-dependent (per DSM-IV criteria) individuals were recruited from outpatient addiction clinics and detoxification units and assessed for eligibility. Intention-to-treat analyses of efficacy end points were performed with all randomized participants.

INTERVENTIONS Randomization to either daily oral flexible dose buprenorphine-naloxone, 4 to 24 mg/d, or extended-release naltrexone hydrochloride, 380 mg, administered intramuscularly every fourth week for 12 weeks.

MAIN OUTCOMES AND MEASURES Primary end points (protocol) were the randomized clinical trial completion rate, the proportion of opioid-negative urine drug tests, and number of days of use of heroin and other illicit opioids. Secondary end points included number of days of use of other illicit substances. Safety was assessed by adverse event reporting.

RESULTS Of 159 participants, mean (SD) age was 36 (8.6) years and 44 (27.7%) were women. Eighty individuals were randomized to extended-release naltrexone and 79 to buprenorphine-naloxone; 105 (66.0%) completed the trial. Retention in the extended-release

Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial

Joshua D Lee, Edward V Nunes Jr, Patricia Novo, Ken Bachrach, Genie L Bailey, Snehal Bhatt, Sarah Farkas, Marc Fishman, Phoebe Gauthier, Candace C Hodgkins, Jacquie King, Robert Lindblad, David Liu, Abigail G Matthews, Jeanine May, K Michelle Peavy, Stephen Ross, Dagmar Salazar, Paul Schkolnik, Dikla Shmuelli-Blumberg, Don Stablein, Geetha Subramaniam, John Rotrosen

Lancet, 2018

Lancet 2018; 391: 309–18
Published Online November 14, 2017
http://dx.doi.org/10.1016/S0140-6736(17)32812-X
See Comment pages 283 and 284

Summary

Background Extended-release naltrexone (XR-NTX), an opioid antagonist, and sublingual buprenorphine-naloxone (BUP-NX), a partial opioid agonist, are pharmacologically and conceptually distinct interventions to prevent opioid relapse. We aimed to estimate the difference in opioid relapse-free survival between XR-NTX and BUP-NX.

Methods We initiated this 24 week, open-label, randomised controlled, comparative effectiveness trial at eight US community-based inpatient services and followed up participants as outpatients. Participants were 18 years or older, had Diagnostic and Statistical Manual of Mental Disorders-5 opioid use disorder, and had used non-prescribed opioids in the past 30 days. We stratified participants by treatment site and opioid use severity and used a web-based permuted block design with random equally weighted block sizes of four and six for randomisation (1:1) to receive XR-NTX or BUP-NX. XR-NTX was monthly intramuscular injections (Vivitrol; Alkermes) and BUP-NX was daily self-administered buprenorphine-naloxone sublingual film (Suboxone; Indivior). The primary outcome was opioid relapse-free survival during 24 weeks of outpatient treatment. Relapse was 4 consecutive weeks of any non-study opioid use by urine toxicology or self-report, or 7 consecutive days of self-reported use. This trial is registered with ClinicalTrials.gov, NCT02032433.

Findings Between Jan 30, 2014, and May 25, 2016, we randomly assigned 570 participants to receive XR-NTX (n=283) or BUP-NX (n=287). The last follow-up visit was Jan 31, 2017. As expected, XR-NTX had a substantial induction hurdle: fewer participants successfully initiated XR-NTX (204 [72%] of 283) than BUP-NX (270 [94%] of 287;

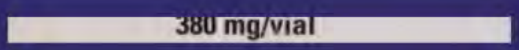
Lancet

Findings:

- **Only 72% initiated XR-NXT** (204/283) vs **94%** 270/287 for BUP-NX p<0.0001
- **Relapse rates > XR-NTX** than BUP-NX (**65% vs 57%**)

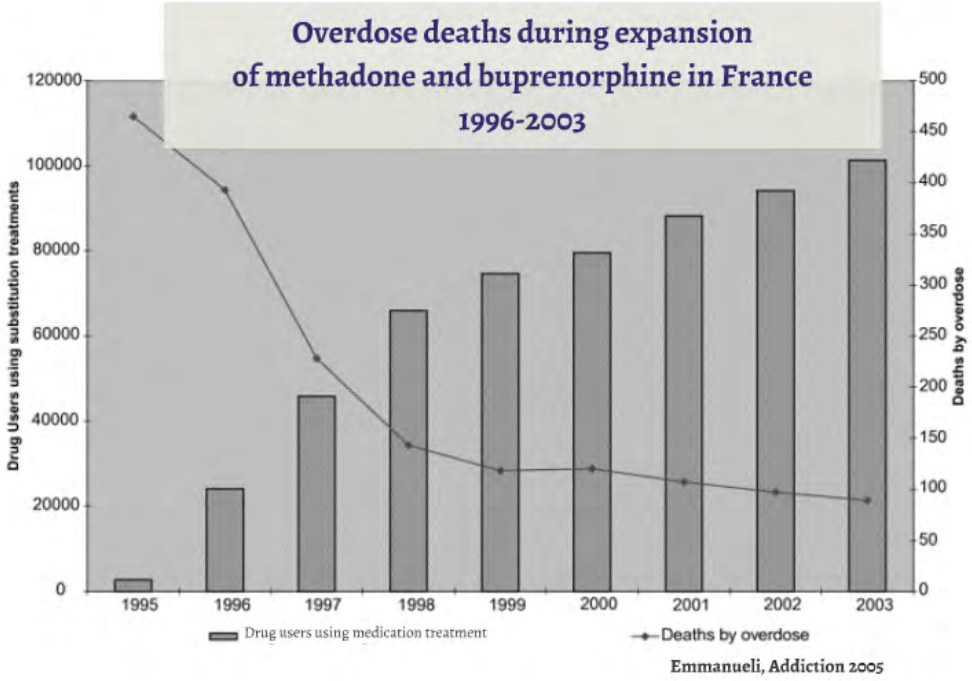
Interpretation:

Once initiated both medications were equally safe a[illegible]ive



Evidence

RESEARCH



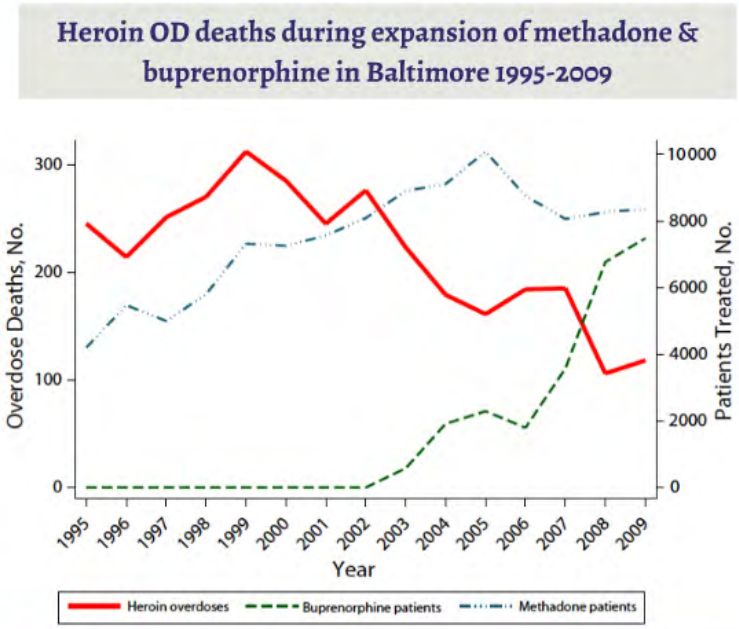


FIGURE 1—Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009.

Schwartz, AJPH, 2013

RESEARCH

Cochrane Library

Cochrane Database of Systematic Reviews

Methadone and Buprenorphine are equally effective

↓ **Opioid use**

\+ **Retention in treatment**

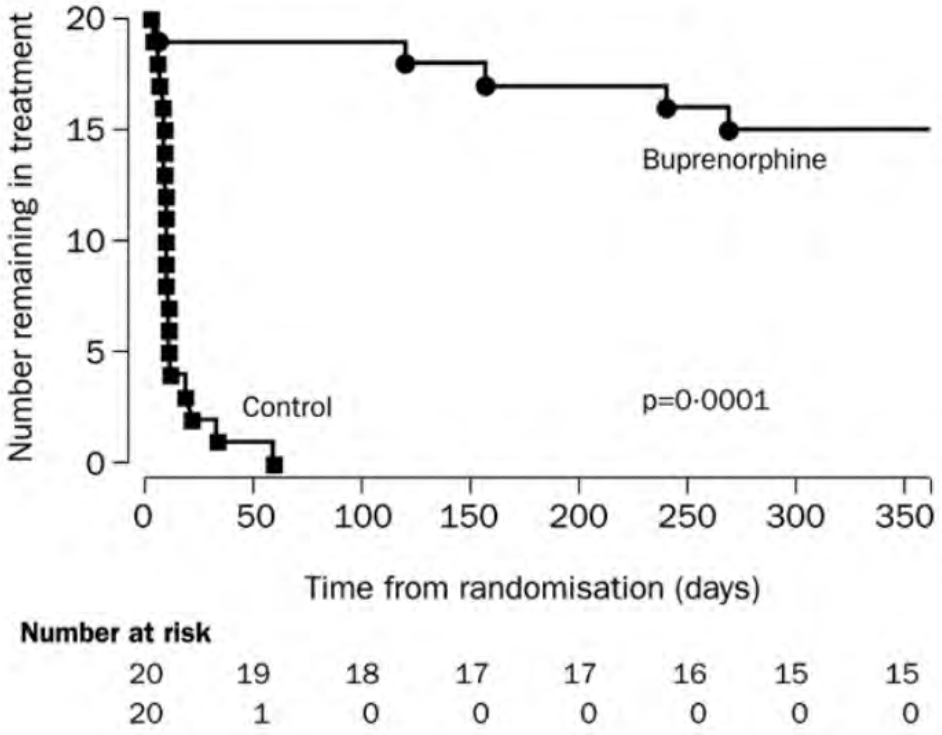
(at adequate dosing)

Mattick et al., 2014

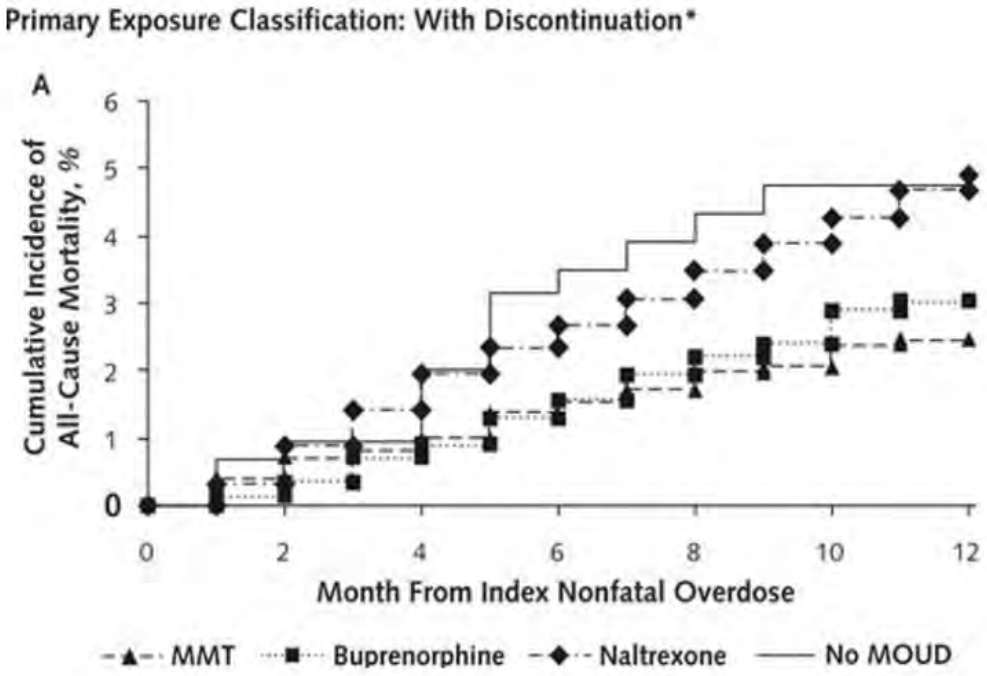
"Present evidence suggests that adding psychosocial support does not change the effectiveness of retention in treatment and opioid use during treatment."

Amato et al, 2011

Medication for Opioid Use Disorder



Kakko. Lancet 2003



Larochelle et al., Annals of IM 2018

Why the ED?


Because that's where the patients are!

A Randomized Trial of ED-Initiated Interventions for Opioid Dependence

Research

Original Investigation

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

JAMA Report V
Author Video
jama.com

CME Quiz at
jamanetwo
CME Ques

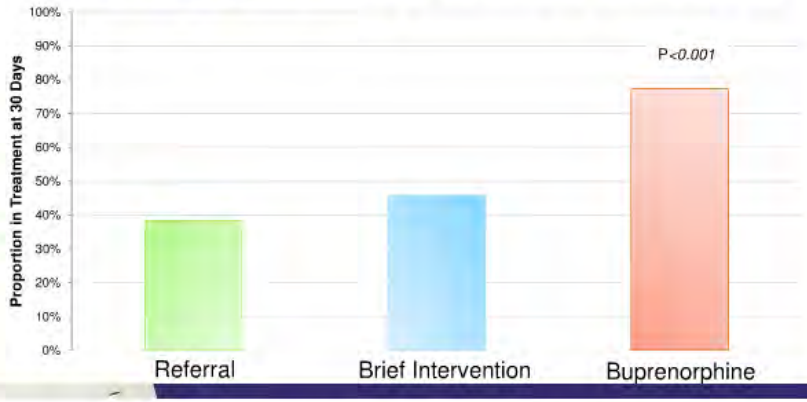
IMPORTANCE Opioid-dependent patients often use the emergency department (ED) for medical care.

OBJECTIVE To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

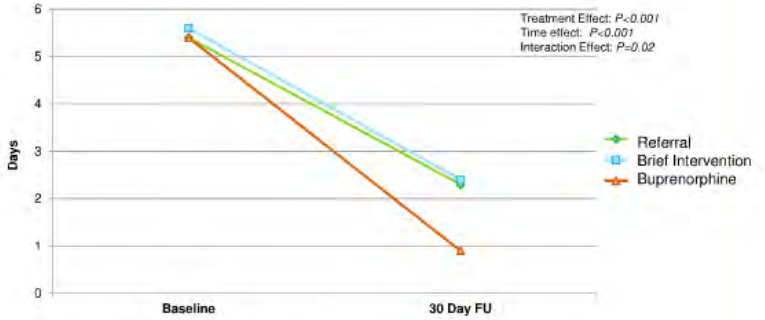
DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial involving 329 opioid-dependent patients who were treated at an urban teaching hospital ED from April 7, 2009, through June 25, 2013.

INTERVENTIONS After screening, 104 patients were randomized to the referral group, 111 to

Engaged in Treatment 30-Days



Past 7 Day illicit Opioid Use

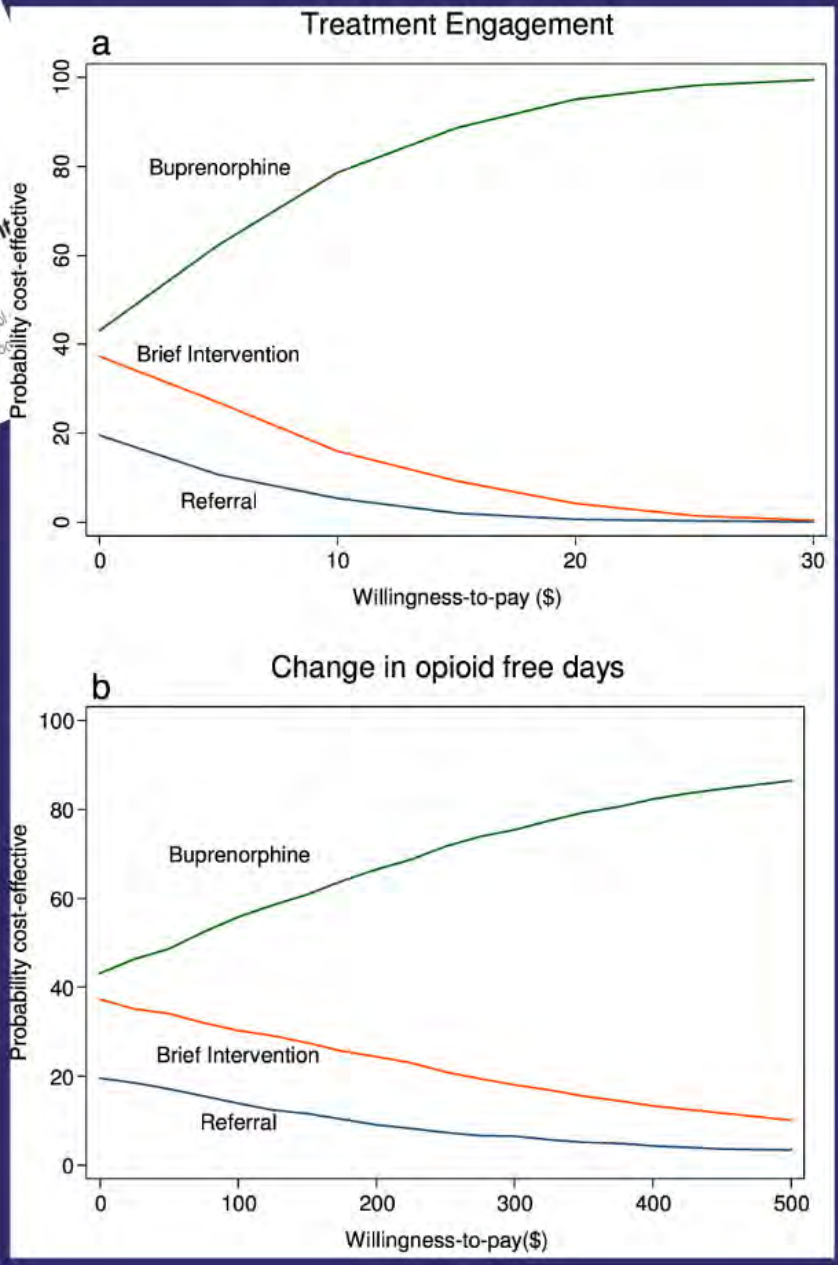


JAMA, 2015

Conclusion

ED-initiated buprenorphine treatment with follow-up medical management in primary care is superior compared with Referral and Brief Intervention at 30 days in:

- Engaging patients in treatment
- Reducing days of illicit opioid use
- Reducing inpatient addiction treatment



Cost-effective acceptability curve: base case analysis.

(a) Willingness-to-pay for a 1 percentage point increase in the probability a patient is engaged in treatment 30-days post-enrollment.

(b) Willingness-to-pay for 1 additional opioid-free day in the past 7-days

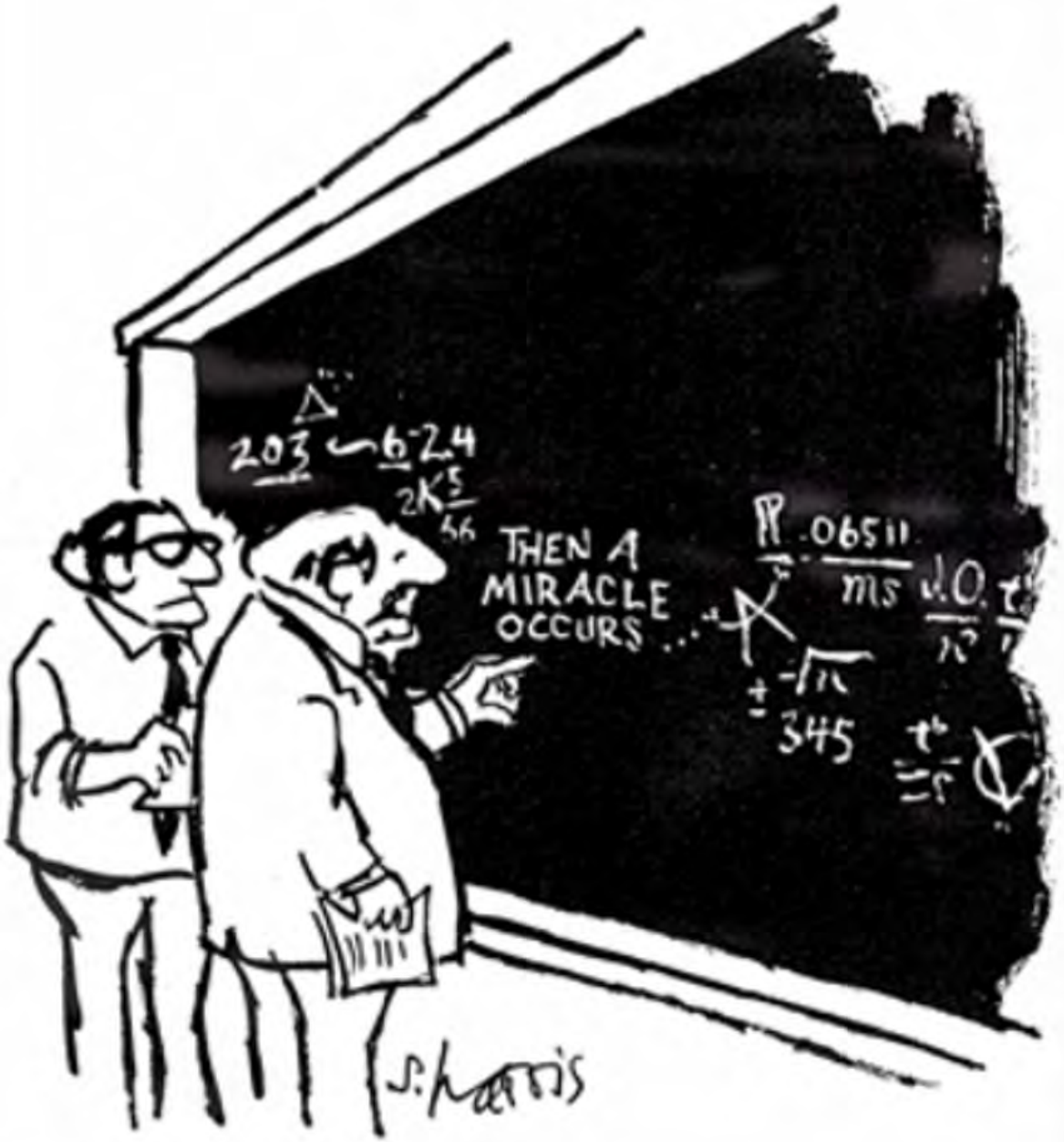
Addiction, 2017

Overdose

22 year old female presents to ED in private vehicle driven by friends. On arrival patient pulled out of vehicle by ED staff, unresponsive with O_2 Sat of 53%. Patient responded well to IV naloxone. Just 2 weeks before, she switched from prescription drugs to IV heroin.

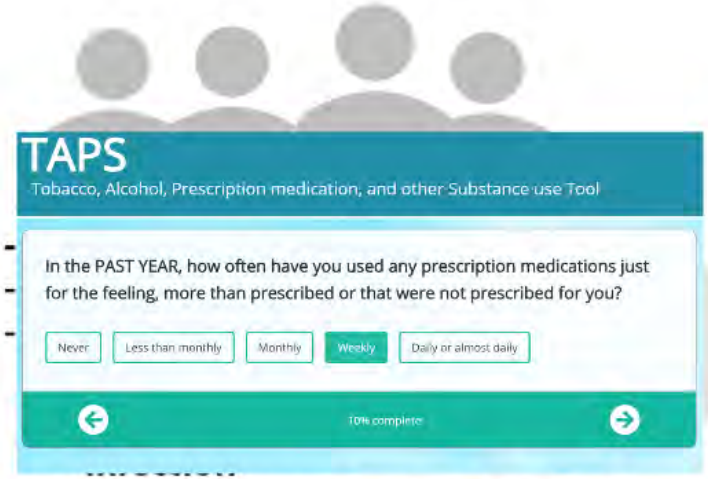
Why is this different than any other acute emergency??

What do I need to do?



"I THINK YOU SHOULD BE MORE EXPLICIT HERE IN STEP TWO."

Buprenorphine Integration Pathway



-Identified during the course of the visit

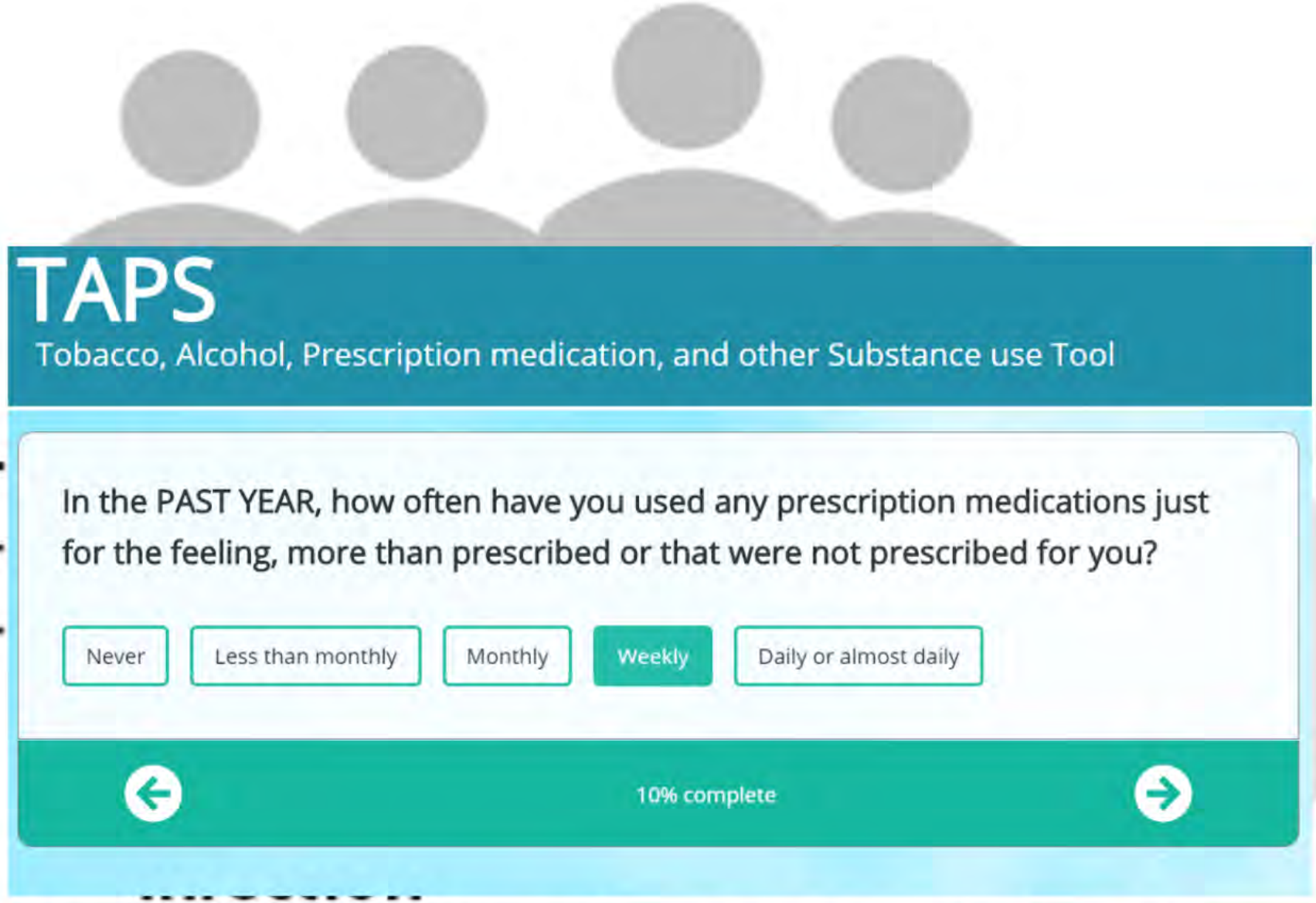
W

③Treat

BNI
Buprenorphine
algorithm

④ Discharge

How do you motivate patients to accept treatment?



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-

-Identified during the course of the visit

WWW.WEBADDRESSHERE.COM
QR CODE

Clinical Opiate Withdrawal Scale (COWS)

For each item, select the appropriate description of the patient's signs or symptoms (points per symptom)

							Score
1.	Resting Pulse Rate	80 or below (0)	**81 - 100 (1)**	101 - 120 (2)	> 120 (4)		1
2.	Restlessness	Able to sit still (0)	Some difficulty sitting still (1)	Frequent shifting of limbs (3)	**Unable to sit still (5)**		5
3.	Anxiety or irritability	None (0)	Increasing amounts (1)	**Obviously irritable/anxious (2)**	Too difficult to participate (4)		2
4.	Yawning	No yawning (0)	1 or 2 times/asessment (1)	**3 or 4 times/assessment (2)**	Several times/minute (4)		2
5.	Pupil Size	Normal (0)	**Possibly larger (1)**	Moderately dilated (2)	Only rim of iris visible (5)		1
6.	Runny nose or tearing	Not present (0)	**Stuffiness/moist eyes (1)**	Nose running/tearing (2)	Constant running/ tears streaming (4)		1
7.	Tremor	No tremor (0)	Felt - not observed (1)	Slight tremor observable (2)	**Gross tremor/twitching (4)**		4
8.	Sweating	No report (0)	Subjective report (1)	Flushed / observable (2)	**Beads of sweat (3)**	Streaming down face (4)	3
9.	Gooseflesh skin	Skin is smooth (0)	**Piloerection/hairs standing (3)**	Prominent piloerrection (5)			3
10.	Bone or joint pain	Not present (0)	Mild discomfort (1)	**Severe aching (2)**	Unable to sit due to pain (4)		2
11.	GI upset	No symptoms (0)	**Stomach cramps (1)**	Nausea or loose stool (2)	Vomiting or diarrhea (5)	Multiple episodes (5)	1

Return to treatment options

< 8 | 8 - 13 | > 13

Moderate-to-Severe

25

How do you motivate patients to accept treatment?

Brief Negotiation Interview

Raise The Subject

- Establish rapport
- Raise the subject of drug use
- Assess comfort

Provide Feedback

- Review patient's alcohol and/or drug use and patterns
- Make connection between AOD use and negative consequences; (e.g. impaired judgment leading to injury/unprotected sex/sharing needles)
- Make a connection between AOD use and ED visit

Enhance Motivation

Assess readiness to change: One a scale 1 to 10 how ready are you to stop using, cut back or enroll in program???

(Why didn't you pick a lower number?)

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ACAD EMERG MED • March 2005, Vol. 12, No. 3 • www.aemj.org

SPECIAL CONTRIBUTIONS

Development and Implementation of an Emergency Practitioner–Performed Brief Intervention for Hazardous and Harmful Drinkers in the Emergency Department

Gail D'Onofrio, MD, MS, Michael V. Pantalon, PhD, Linda C. Degutis, DrPH, David A. Fiellin, MD, Patrick G. O'Connor, MD

Abstract

Objectives: 1) To develop and teach a brief intervention (BI) for "hazardous and harmful" (HH) drinkers in the emergency department (ED); 2) to determine whether emergency practitioners (EPs) (faculty, residents, and physician associates) can demonstrate proficiency in the intervention; and 3) to determine whether it is feasible for EPs to perform the BI during routine clinical care. **Methods:** The Brief Negotiation Interview (BNI) was developed for a population of HH drinkers. EPs working in an urban, teaching hospital were trained during two-hour skills-based sessions. They were then tested for adherence to and competence with the protocol using standardized patient scenarios. The components of the BNI were identified as critical components of the BNI. Finally, the BNI as part of routine ED clinical care was tested in a randomized controlled trial to evaluate patient outcomes. **Results:** The BNI was developed, modified, and finalized in a manual, based on pilot testing. Eleven training sessions with 58 EPs were conducted from March 2002 to August 2003. Ninety-one percent (53/58) of the trained EPs passed the proficiency examination; 96% passed after remediation. Two EPs left prior to remediation. Subsequently, 247 BNIs were performed by 47 EPs. The mean (± standard deviation) number of BNIs per EP was 5.28 (±4.9), range 0–28). The mean duration of the BNI was 7.75 minutes (±3.18; range 4–24). **Conclusions:** A BNI for HH drinkers can be successfully developed for EPs. EPs can demonstrate proficiency in performing the BNI in routine ED clinical practice. **Key words:** alcohol problems; brief interventions; motivational enhancement. ACADEMIC EMERGENCY MEDICINE 2005; 12:249–256.

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ORIGINAL RESEARCH

An interventionist adherence scale for a specialized brief negotiation interview focused on treatment engagement for opioid use disorders

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ABSTRACT

Background: No psychometrically validated instrument for evaluating the extent to which interventionists correctly implement brief interventions designed to motivate treatment engagement for opioid use disorders has been reported in the literature. The objective of this study was to develop and examine the psychometric properties of the Brief Negotiation Interview (BNI) Adherence Scale for Opioid Use Disorders (BAS-O). Methods: In the context of a randomized controlled trial evaluating the efficacy of 3 models of emergency department care for opioid use disorders, the authors developed and subsequently examined the psychometric properties of the BAS-O, a 38-item scale that required raters to answer whether or not ("Yes" or "No") each of the critical actions of the BNI was correctly implemented by the research interventionist. BAS-O items were obtained from the BNI's 4 elements: (1) Raise the Subject (2) Provide Feedback (3)

KEYWORDS

Enhance Motivation

Assess readiness to change: One a scale 1 to 10 how ready are you to stop using, cut back or enroll in program???

(Why didn't you pick a lower number?)

Negotiate

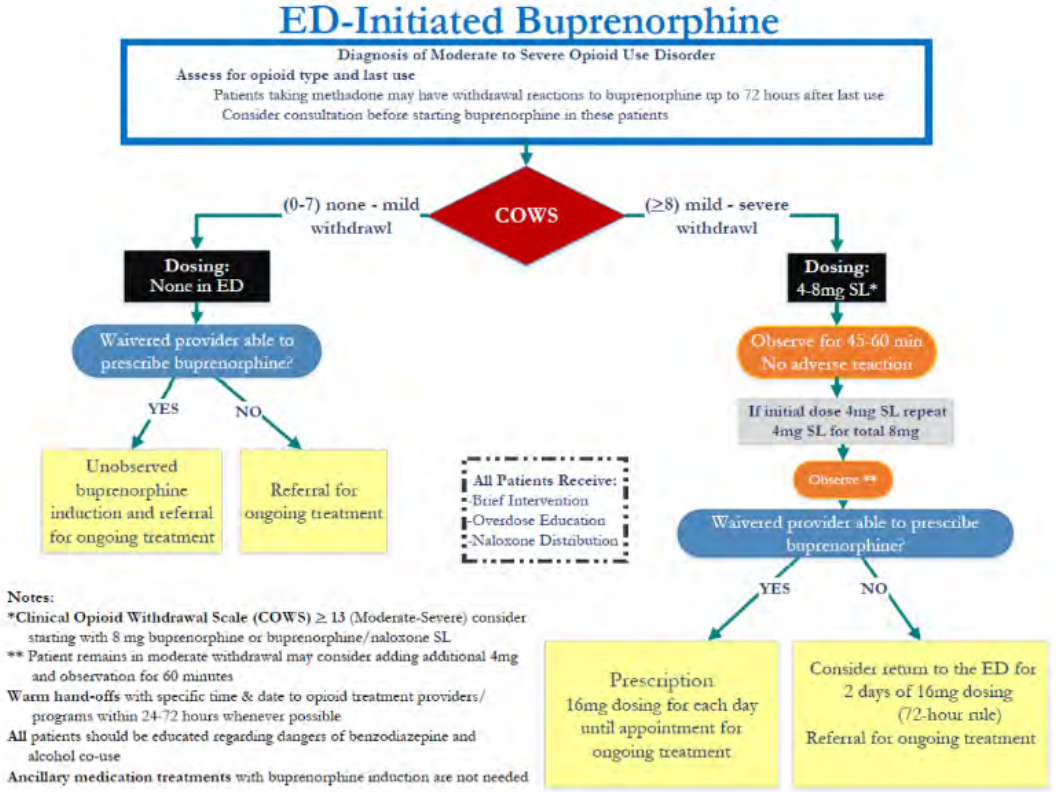
- Negotiate goal
- Give advice
- Summarize and complete referral/prescription form
- Thank patient for their time

D'Onofrio G, Pantalon MV, Degutis LC, Fiellin DA, O'Connor PG. Development and implementation of an emergency practitioner-performed brief intervention for hazardous and harmful drinkers in the emergency department. Acad Emerg Med 2005;12:249-256.

ED-Initiated Buprenorphine

③ Treat

BNI Buprenorphine algorithm



Buprenorphine side effects

Mild, early, often resolve

Headache
Nausea
Sweating
Constipation
Libido

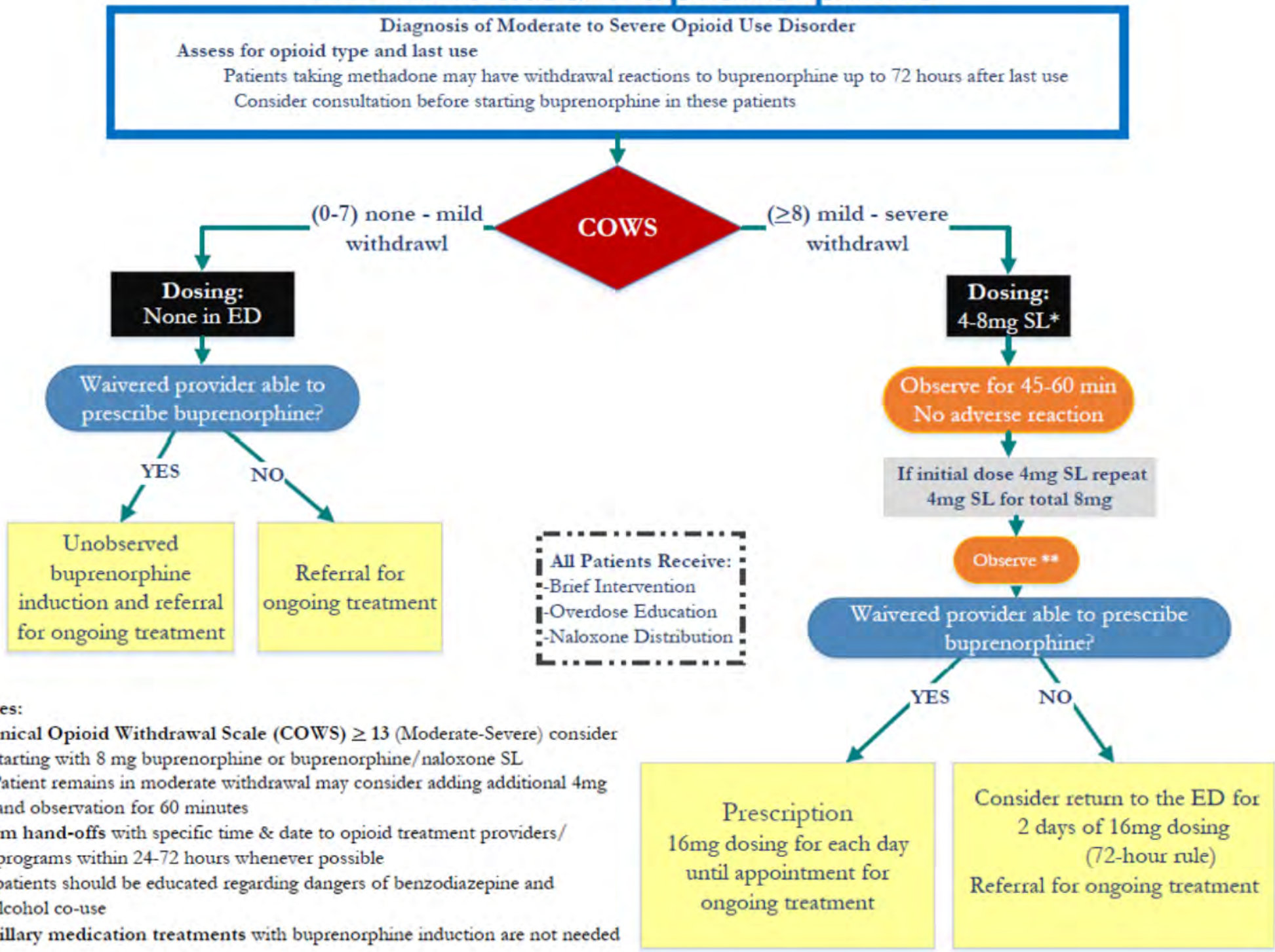
Severe

Precipitated withdrawal

Dose?

Most patients
Day 1
1st dose = 4-8 mg buprenorph
depending on COWS
(Max 12 mg 1st day)
Days 2 through referral
16 mg, once a day

ED-Initiated Buprenorphine



Notes:

***Clinical Opioid Withdrawal Scale (COWS) ≥ 13** (Moderate-Severe) consider starting with 8 mg buprenorphine or buprenorphine/naloxone SL

** Patient remains in moderate withdrawal may consider adding additional 4mg and observation for 60 minutes

Warm hand-offs with specific time & date to opioid treatment providers/ programs within 24-72 hours whenever possible

All patients should be educated regarding dangers of benzodiazepine and alcohol co-use

Ancillary medication treatments with buprenorphine induction are not needed

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Headache

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Sweating

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Severe

Precipitated withdrawal

Dose?

Most patients

Day 1

1st dose = 4-8 mg buprenorphine depending on COWS (Max 12 mg 1st day)

Days 2 through referral

16 mg, once a day

④ Discharge

BUPRENORPHINE REFERRAL FORM FOR OPIOID USE DISORDER

Instructions: Buprenorphine/naloxo
suppressing withdrawal symptoms.
of buprenorphine in the hospital, a
this form to local treatment center

Patient's Name: _____
Phone number: (_____) ____
Insurance: ☐ Medicaid/Me
Presented to ED with opioid ove

Opioid Use History:
Age of first use: _____ Pri
Pattern of opioid use (average da

Substance Use History (other tha
- ☐ cocaine
- ☐ alcohol
- ☐ benzodiazepines

Medical/Psychiatric History: ___

_____

Critical actions required by the E
DSM 5 Score for opioid dependen
COWS Score (Score must be ≥8): _

Buprenorphine started in ED: ☐
Dose given: _____ Rx dose___
Number of days given (Rx):_____

Name of referring ED provider: _

Contact number: (_____) ___

Completed form sent by EHR, faxed OR to (please check one). (List frequent referrals sites)

Note: For all treatment options include information on what insurance types are accepted and appointment times, availability or contact. Include

A Guide for Patients Beginning Buprenorphine Treatment at Home

Before you begi

It should be at least .

- **12 hours** since you used heroin/
- **12 hours** since snorted pain pills
- **16 hours** since you swallowed pa
- **48-72 hours** since you used met

Once you are

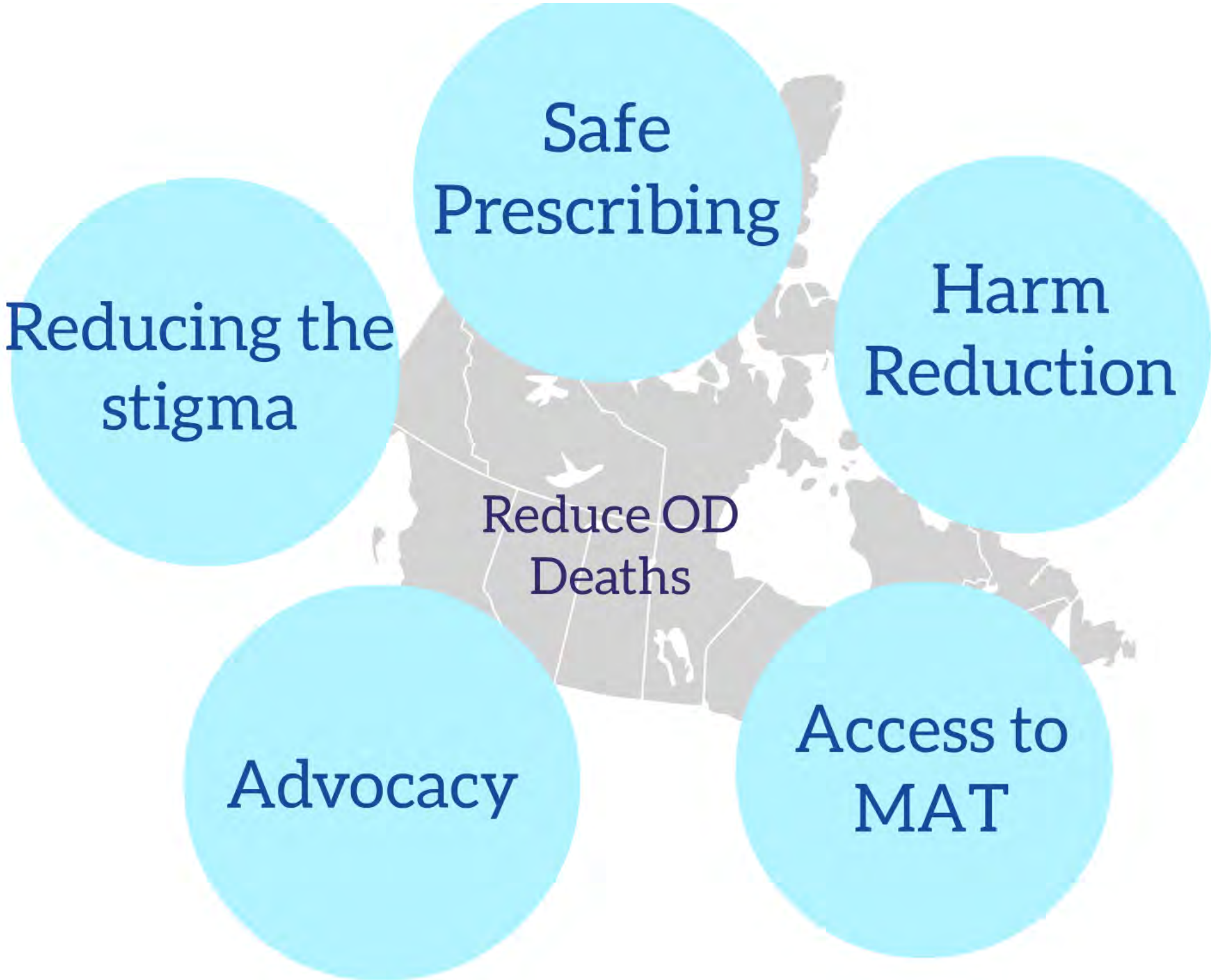
Most people feel better the first day

Step 1.

Take the first dose	Wait 45 minutes
4mg	45 minutes

- Put the tablet or strip under your tongue
- Keep it there until fully dissolved (about 15 min.)
- Do NOT eat or drink at this time
- Do NOT swallow the medicine

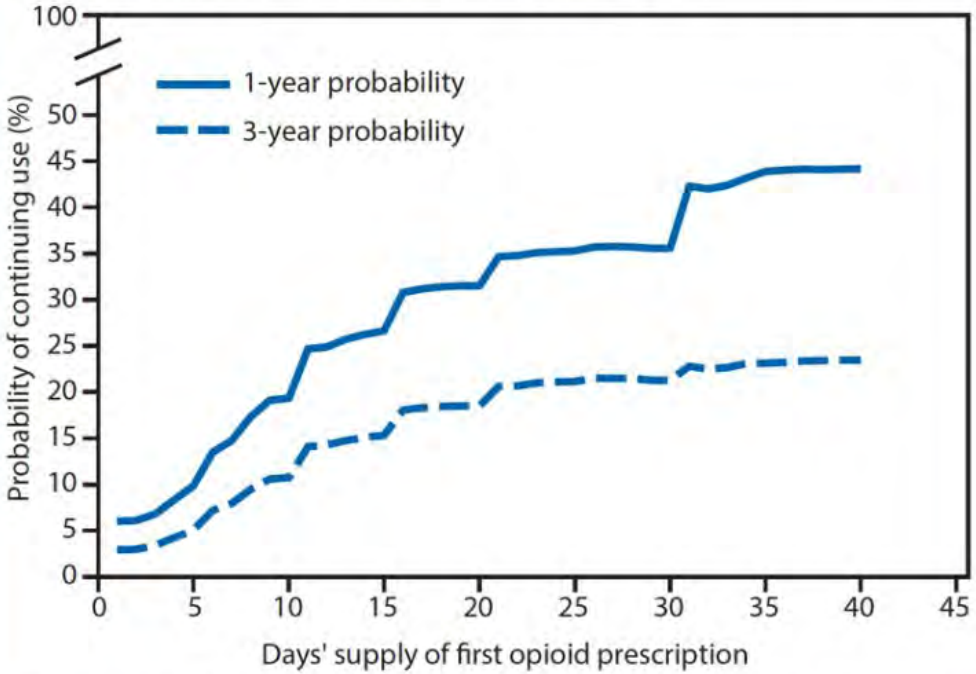
If you develop worsening symptoms while starting buprenorphine before your scheduled outpatient appointment return to the emergency department


Safe Prescribing
Reducing the stigma
Harm Reduction
Reduce OD Deaths
Advocacy
Access to MAT

Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015

Safe Prescribing

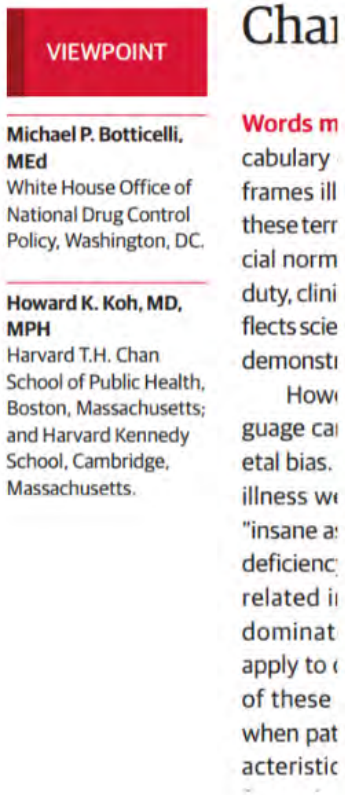
FIGURE 1. One- and 3-year probabilities of continued opioid use among opioid-naïve patients, by number of days' supply* of the first opioid prescription — United States, 2006–2015



* Days' supply of the first prescription is expressed in days (1–40) in 1-day increments. If a patient had multiple prescriptions on the first day, the prescription with the longest days' supply was considered the first prescription.

Shah A, MMWR, March 17, 2017

Reducing the stigma



VIEWPOINT

Cha

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Words m
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Words Matter

Words are powerful... They can contribute to stigma and create barriers to accessing effective treatment

Use person-first language; focus on the person, not the disorder

When Discussing Opioid or Other Substance Use Disorders...

Avoid These Terms:	Use These Instead:
Addict, user, drug abuser, junkie	Person with opioid use disorder or person with opioid addiction, patient
Addicted baby	Baby born with neonatal abstinence syndrome
Opioid abuse or opioid dependence	Opioid use disorder
Problem	Disease
Habit	Drug addiction
Clean or dirty urine test	Negative or positive urine drug test
Opioid substitution or replacement therapy	Opioid agonist treatment
Relapse	Return to use
Treatment failure	Treatment attempt
Being clean	Being in remission or recovery

Adapted from: National Council for Behavioral Health

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Embrace science based treatments

Engage other emergency physicians

Change the trajectory of the opioid epidemic


ED BRIDGE
Emergency Buprenorphine Treatment
Need help with pain pills or heroin?
We want to help you get off opioids and started on Suboxone (Buprenorphine).
Ask here for more information.

in Canada die fr

Faces of Addiction

WHITEHORSE

YELLOWKNIFE

Steven Howe
1982-2015
Alberta
Fentanyl related OD

Alexandria Sanderson
1995-2017
Manitoba
Fentanyl Overdose

Andrew Gallager
1987-2016
British Columbia
Accidental Overdose

EDMONTON

SASK

WHISTLER

BANFF

VANCOUVER

CALGARY

VICTORIA

REGINA

Stephanie Vermiere
1988-2017
Manitoba
Fentanyl poisoning

WINNIPEG

CHARLOTTETOW

QUEBEC CITY

MONTREAL

OTTAWA

TORONTO

NIAGARA FALLS


And Lets Change
The way we THINK about addiction
The way we TALK about addiction
The way we TREAT addiction
CORE 2016