Accidental opioid overdoses: A public health crisis

From January 2016 - June 2019, there were nearly 14,000 apparent opioid-related deaths in Canada. Ontario is not immune to this tragedy. Within the first six months of 2019 alone, there were 937 apparent opioid-related deaths - an average of 5 per day.

The crisis shows no signs of slowing down. Our governments must respond to this public health crisis.

RNAO recommends that the provincial government:

- Lift the cap on the number of Consumption Treatment Services (CTS) sites and provide these services in every community where services are needed
- Ensure sufficient funding and support to address shortages of treatment options, recovery resources and mental health and addiction services mandated by the CTS model
- Obtain a province-wide exemption to Section 56.1 of the *Controlled Drugs and Substances Act* (CDSA) from the federal government
- Streamline and expedite the province's CTS application process to prevent unnecessary deaths

Background

History of the crisis

The origins of the current opioid crisis date back at least three decades. Opioids such as codeine, fentanyl, morphine, oxycodone, hydromorphone, and heroin, relieve pain. The prescription of opioids increased significantly in the 1990s as drug companies developed and marketed new formulations of opioids. One of the first examples in Canada, OxyContin, was introduced to the market by Purdue Pharma in 1996. This was followed by an extended period of high rates of opioid prescribing.

By 2012, there was growing awareness of over-prescribing, as well as serious risks associated with opioid use, including physical dependence, substance use disorder and overdose. This led to efforts to decrease prescribing through drug formulation changes, developing prescribing guidelines, and restricting access to high-strength opioids. However, an unintended consequence of these actions was an increase in street drug use.

The rapid escalation of deaths since 2016 can be attributed to the growing toxicity of the illegal drug supply, including potent forms of opioids such as fentanyl and carfentanil. Between 2017 and 2018, fentanyl and fentanyl analogues contributed to deaths in 71.2 per cent of accidental opioid-related overdoses in Ontario.

Changing political landscape

In 2011, a case against Insite in Vancouver – the first supervised injection services (SIS) site in North America – made its way to the Supreme Court of Canada. The court concluded: “Insite has been proven to save lives with no discernible negative impact on the public safety and health objectives of Canada.” The court gave the federal government one year to revise its policies to allow for legal operation of SIS in Canada.

In 2017, unsanctioned SIS pop-ups began operating in Toronto and Ottawa in response to the need for overdose prevention services in these communities. Sanctioned interim sites soon followed. In December 2017, Health Canada allowed provinces to request an exemption under the *Controlled Drugs and Substances Act* for temporary overdose prevention services (OPS) to respond to the increasing opioid crisis. In January 2018, the Ontario government expedited applications to establish OPSs. By July 2018, there were 16 SIS or OPS sites operating across the province.

What are supervised consumption services?

Supervised consumption services (SCS) include supervised injection services (SIS), overdose prevention services (OPS) and consumption treatment services (CTS). SCS keep people alive. These services allow people to inject previously-obtained drugs under the supervision of registered nurses (RN), nurse practitioners (NP), and other trained health workers. They provide sterile supplies, overdose prevention and management, as well as other health and social support services, including:

- Supervised consumption (injection, intranasal, oral) and overdose prevention intervention
- Onsite or defined pathways to addiction treatment services
- Onsite or defined pathways to wrap-around services including: primary care, mental health, housing and/or other social supports
- Additional harm reduction services such as education, distribution and disposal of harm reduction supplies, and the provision of naloxone and oxygen

These recent changes are happening during a period of mounting lawsuits, from both provinces and individuals, against drug manufacturers, distributors, and wholesalers over their practices related to marketing and lack of oversight over the high rates of distribution. In the US, the state of Oklahoma successfully won its case against Johnson & Johnson, arguing the drug company engaged in misleading marketing of opioids that overstated drug effectiveness for chronic pain and understated the risk of addiction. In Canada, British Columbia launched a national class action suit against more than 40 drug manufacturers and wholesalers in 2018. Ontario joined this suit in 2019, which alleges drug companies falsely marketed opioids as less addictive than other pain drugs and helped trigger the overdose crisis.

RNAO recommendations

For more than a decade, RNAO has urged that evidence-informed drug policy be implemented. In 2011, RNAO joined a nursing coalition in support of keeping Insite open. From 2013 to 2016, RNAO demanded the Ontario government open and fund SIS/OPS sites and legalize and regulate drugs.

To support the clinical practice of nurses and others working with people who inject drugs, RNAO released the best practice guideline (BPG) *Implementing supervised injection services* in February 2018. RNAO undertook this work in response to the growing need in our province, and at the request of Toronto's then Medical Officer of Health Dr. David McKeown, who served as panel co-chair for the guideline. Like all RNAO BPGs, it was developed using a systematic review of evidence and extensive consultation with an expert panel, including people with lived experience. The 11 recommendations cover a range of topics, including integrating peer workers and health and social services into programming, as well as aligning future locations and operations according to local population needs.

RNAO approach: Harm reduction

The crisis of opioid-related deaths demands immediate action using a harm reduction approach. Harm reduction is an evidence-based, person-centred approach that prevents or lessens the harms associated with substance use and addiction. It includes a series of programs, services and practices that provide people who use substances with choices on how they can minimize harms through non-judgemental and non-coercive strategies.

RNAO considers the current response to this public health crisis inadequate. It has resulted in preventable deaths, and thousands of hospitalizations and emergency department visits. RNAO urges the following changes to the government's response:

1. *Provide a comprehensive treatment service site to every community in need of one*

The government has arbitrarily capped the number of CTS sites at 21. SCS are a demonstrated life-saving intervention. The number of sites must reflect need. To save lives, the government should lift the cap on CTS sites and provide consumption treatment services in every community in need of such services.

2. *Streamline and expedite the province's CTS application process to prevent unnecessary deaths*

The approval process for CTS sites involves meeting both federal and provincial requirements. The federal application requires proof of public consultation, detailed site floor plans, and confirmed sources of funding. The provincial application process demands many of the same undertakings including detailed site requirements and extensive public consultations. This onerous and duplicative application process creates inaction where urgent action is needed.

In addition, a coroner's jury looking into the death of Bradley Chapman, a Toronto man who died of an accidental overdose in August 2015, flagged requirements of the CTS program that can affect access to services. The federal public consultation process is already problematic and the province's additional requirements to consult with groups resistant to supervised injection services has the potential to cause further harm by giving multiple platforms to express discrimination. Such requirements encourage a 'not-in-my-backyard' mentality over science, and prevent a timely and appropriate response to this public health crisis. The extensive requirements under the CTS model also impose increased workload, uncertainty, and fear among health professionals already struggling to respond to those in need.

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