Opioid overdoses: Ontario's forgotten public health crisis

Between January 2016 and March 2020, more than 16,000 Canadians died from accidental opioid overdose. Ontario is not immune to this tragedy. It accounts for 5,561 of those deaths. As we have seen globally and nationally, Ontario's overdose crisis has deepened with the onset of the COVID-19 pandemic. On average, in the first 3.5 months of the pandemic in Ontario, more than 6 people died each day from an opioid-related overdose, representing a 38 per cent increase in deaths compared to before the pandemic. If this devastating trend continues, more than 2,200 opioid-related deaths are expected in Ontario in 2020, with a disproportionate number occurring in neighbourhoods with higher ethno-cultural diversity.

Evidence shows that the number of deaths will continue to rise amid the COVID-19 pandemic due to the myriad factors that have disproportionately affected people who use substances. The unintended consequences of COVID-19-related public health measures on people who use substances include: increased social isolation; decreased availability and access to direct services and supports; negative implications on mental health; and unsupported withdrawal. Urgent evidence-based action is required to stem the loss of life as COVID-19 intersects with the opioid overdose crisis and further marginalizes and stigmatizes vulnerable Ontarians.

RNAO recommends that the provincial government:

1. Approve and fund the 21 Consumption and Treatment Services (CTS) sites announced in 2018 and concurrently lift the cap on CTS sites in an effort to expand these services to every community in need.
2. Streamline and expedite the CTS site application process to prevent unnecessary deaths.
3. Obtain a province-wide exemption to Section 56.1 of the *Controlled Drugs and Substances Act* (CDSA) from the federal government.
4. Fund and support the expansion of safer supply initiatives for those at high risk of overdose, in a co-ordinated approach with the federal government.

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 the use of street drugs.

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. In 2019, fentanyl and fentanyl analogues contributed to deaths in 80 per cent of accidental opioid-related deaths in Ontario, a 35 per cent increase since 2016.

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 and 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 use previously-obtained illicit 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 onsite or defined pathways to:

- Supervised consumption (injection, ingestion and/or inhalation) and overdose prevention intervention
- addiction treatment services,
- wrap-around services, including: primary care, mental health care, 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.

In October 2018, the Ontario government announced plans to replace SCS and OPS models with a new model, Consumption and Treatment Services (CTS), with a requirement for existing SCS and OPS to undergo the new application process. An arbitrary limit of 21 CTS sites was set for the province and has not

been changed in two years, despite demonstrated critical need for access to these life-saving harm reduction services in communities across Ontario. A CTS site requires approval from the federal government for a legal exemption under the *Controlled Drugs and Substances Act* (CDSA) to operate a SCS. Without an exemption to operate SCS for medical purposes, people who use substances and operators of SCS are exposed to the risk of criminal prosecution for certain drug offenses under the CDSA. Between August and October 2020, Health Canada sought consultation on the intent to develop new regulations under the CDSA with respect to SCS– recognizing the regulatory burden on SCS applicants and operators with the current process. Presently, 20 of the 38 SCS that are operational in Canada are in Ontario – yet only 16 of those are funded by the provincial government and designated as CTS.

These federal and provincial legislative and regulatory 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 United States (U.S.), Oklahoma has 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, which helped trigger the overdose crisis. Most recently, Purdue Pharma plead guilty to criminal charges over the handling of its addictive prescription opioid OxyContin, in a landmark 2020 settlement in the U.S.

RNAO advocacy

For more than a decade, RNAO has advocated for an evidence-based substance use policy. In 2011, the association was the catalyst in the creation of a coalition of nursing organizations working together to support Insite’s fight to stay 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 its best practice guideline (BPG) *Implementing supervised injection services* in February 2018. RNAO undertook this work in response to the growing need in Ontario, 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 within the BPG 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 starkly insufficient. It has resulted in preventable deaths and thousands of hospitalizations and emergency department visits.

RNAO recommendations

RNAO urges the following changes to the government's response:

1. ***Approve and fund the 21 Consumption and Treatment Services (CTS) sites announced in 2018 and concurrently lift the cap on CTS sites in an effort to expand these services to every community in need.***

The federal government has yet to fund the 21 CTS sites that it committed to in 2018. Moreover, given this cap on sites was arbitrary, and SCS are a demonstrated life-saving intervention, RNAO is calling on government to lift the cap of 21 CTS sites immediately. SCS have the potential to reduce the number of fatal and non-fatal substance overdoses, reduce the spread of infectious diseases, connect people with wrap-around health and social services, foster safer communities and provide cost-savings. The number of sites must reflect the need. To save lives, the government should expand consumption and treatment services to every community in need.

2. ***Streamline and expedite the CTS site 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 requirement for public consultation is problematic and the province's additional requirements to consult with groups resistant to SIS has the potential to cause further harm by giving multiple platforms to stigmatize substance use and users. Such requirements encourage NIMBYism (not in my backyard) over evidence, 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.

3. ***Obtain a province-wide exemption to Section 56.1 of the Controlled Drugs and Substances Act (CDSA) from the federal government.***

As per the CDSA, section 56.1 currently requires an application to the federal ministry of health for an exemption to operate SCS for medical purposes in Canada. RNAO recommends that Ontario obtain a province-wide exemption to section 56.1 of the CDSA to streamline the process of applying for CTS, reflective of the urgent needs of Ontarians accessing these vital services. It is not feasible for smaller organizations in communities across Ontario to adhere to the burdensome federal and provincial

administrative processes. The implementation of life-saving services should be based on evidence of need and the potential for benefit in addressing that need. Supervised consumption and overdose prevention should not be treated any differently.

4. Fund and support the expansion of safer supply initiatives for those at high risk of overdose, in a co-ordinated approach with the federal government.

At the intersection of dual public health emergencies (the opioid overdose crisis and COVID-19), people who use substances are faced with a number of risks. These include fatal or non-fatal overdose, risk of infection, and risks due to withdrawal for those who must self-isolate or quarantine to reduce the spread of COVID-19. The contaminated and toxic illicit drug supply is a major driver of the opioid overdose crisis. An extension of harm reduction beyond supervised consumption and safer supply is a pragmatic and ethical response to this crisis for persons at high risk of overdose. RNAO supports providing low-barrier access to a safer supply of pharmaceutical-grade substances as a safer alternative to the poisoned illicit drug market for individuals at high risk of overdose. Safer supply programs already exist across Ontario, many with funding from the federal government, and are keeping people connected to care and reducing preventable deaths. In August 2020, Canada's minister of health urged all provincial and territorial ministers of health and their regulatory colleges to encourage action at all levels to better provide people who use drugs with a full spectrum of options to receive care – including access to a safer supply. The participation of people with lived experience of substance use in the planning, delivery and evaluation of safer supply initiatives is central to a person-centred approach to responding to the overdose crisis.

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