HARM REDUCTION IN CANADA
LESSONS LEARNED AND REFLECTIONS

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OUTLINE

• Harm reduction
• Canadian context
• Lessons learned
  1. Overdose deaths are preventable
  2. Harm reduction is standard of care
  3. Harm reduction is not enough
• Reflections
  1. Reducing harms in a harm-inducing context
  2. Responding to a toxic drug supply
  3. Restricting access to opioids is not a solution
• Conclusion
HARM REDUCTION

Refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of drugs without necessarily reducing or stopping drug consumption
(Canadian Harm Reduction Network)

Values life, choice, respect and compassion over judgement, stigma, discrimination and punishment
(Source unknown)
HARM REDUCTION

• Harm reduction is:
  • Historically grassroots and community-focused
  • Pragmatic and patient-centered
  • Ethical and non-judgmental
  • Evidence-based and proven to work
  • Cost-efficient and cost-saving
  • Life-saving
  • A human right
CANADIAN CONTEXT
HISTORICAL OVERVIEW

- 1987  First version of the National Drug Strategy
- 1992  Second version of the National Drug Strategy
- 1998  Inclusion of harm reduction pillar
- 2000  Vancouver: Four Pillar Approach to Drug Problems
- 2003  National Drug Strategy renewed with four pillars
- 2006-15 Active opposition to harm reduction (Harper era)
- 2007  Introduction of the National Anti-Drug Strategy
- 2016  Introduction of National Strategy on drugs and other substances (reintroduction of harm reduction)
- 2018  New Democratic Party and Liberal Party vote resolutions to support drug decriminalization
- 2018  The cities of Vancouver, Toronto, and Montreal call for drug decriminalization
FIRST SUPERVISED INJECTION SITE

- Insite (Vancouver)
  - Opened in 2003
  - First supervised injection site in North America
  - 3.6 million clients since opening
  - Average of 400 injection room visits per day
FIRST SUPERVISED INJECTION SERVICE

• Dr. Peter Centre (Vancouver)
  • Opened in 1997 as a centre for people living with HIV
  • First health care facility in North America to integrate supervised injection services in its model of care (2002)
  • Functioned without a federal exemption until 2014
PROCESS

FEDERAL LEVEL (CDSA)
- Criteria for exemption
- Exemption application

PROVINCIAL LEVEL (health care delivery)
- Additional criteria
- Implementation
- Funding
EXEMPTION

- From 26 criteria (2015)
  - Conservative strategy to block SIS
- To 5 criteria (2016)
  - Introduced by Liberals to « streamline »
    - Impact on crime rates
    - Local conditions indicate need for site
    - Regulatory structure in place
    - Resources available to support the maintenance of site
    - Expressions of community support or opposition
OVERDOSE CRISIS

- 2017: 3,987 apparent opioid-related deaths in 2017
- 37% increase from 2016 (2,978)
OVERDOSE CRISIS

• Who is dying?
  • Men (76%)
  • Age
    • 20-29 (20%)
    • 30-39 (27%)
    • 40-49 (22%)
  • Fentanyl or analogues (68%)
  • Involving other substances (72%)
  • Indoors (90%)
OVERDOSE CRISIS

#STOP THE DEATHS

- Scotland is in the midst of an overdose crisis
- It is also faced with an HIV outbreak and high rates of HCV
OVERDOSE CRISIS

#STOP THE DEATHS

- Scotland recorded 934 overdose deaths in 2017
- BC declared a public health emergency in April 2016 when it was predicting 800 deaths. Last year, it recorded close to 1400 deaths

Drug-related deaths in Scotland

2017 - 934
2016 - 868
2015 - 706
2014 - 614
2013 - 527
LESSONS LEARNED
1. OVERDOSE DEATHS ARE PREVENTABLE

- Overdose prevention 101
  - Do not use alone
  - Take your time
  - Test your drug
    - Drug testing continuum: from spectrometry to “test shots”
- Carry naloxone
  - Wide distribution and as easy to obtain as possible
  - Mandatory for all frontline groups: firefighters, police, paramedics, bar staff, librarians, school staff, support workers, prison guards
- Access first aid (including oxygen)
- Call 911
  - Good Samaritan Law
OPIATE ASSISTED THERAPY

SUPERVISED CONSUMPTION SITES
(health care and social services)

POP-UP SITES
OVERDOSE PREVENTION SITES
(overdose first aid)
3 opiate assisted therapy sites: hydromorphone (3) + diacetylmorphine (1)
20+ supervised consumption sites (only 1 with safer inhalation)
20+ overdose prevention sites
20+ managed alcohol programs
OVERDOSE PREVENTION SITES (OPS)

- In British-Columbia (2016)
  - Spring: province declares public health emergency
  - Fall: 1st outdoors pop-up supervised injection sites open
  - December: ministerial order issued by the BC Minister of Health
    - Ex: 108,804 visits to 1 site (Dec 2016-Oct 9) = 255 ODs = 0 deaths
OVERDOSE PREVENTION SITES (OPS)

- In Ontario (2017)
  - Summer: Toronto opens OPS in Moss Park
  - Summer: Ottawa opens OPS in Raphael-Brunet Park
  - December: Health Canada gives exemption to open OPS in ON
  - January: OPS program launches
  - August: OPS program is put on hold (Conservative government)
Total number of visits
Total: 3667
Inhalation: 2616
Injection: 986
Day 52, 66, 67 do not appear in graph due to forced closure (weather)
Breakdown not recorded from day 1 to day 4
OVERDOSE PREVENTION SITES (OPS)

• Why they work?
  • Overdose prevention 101
  • Quick implementation
  • Peer-driven
  • Operate outside heavy bureaucratic structures
  • No barriers
  • Peer-based assisted injection possible
SUPERVISED CONSUMPTION SITES (SCS)

• Research to date (Potier et al., 2014; Kennedy et al., 2017)
  • ↓ overdose-related deaths (no death ever recorded in a site)
  • ↓ in syringe sharing / reuse
  • Safer injection practices including
    • ↑ use of sterile materials
    • Drug checking related to reduced doses
  • ↑ in condom use (Marshall et al., 2008)
• Rapid care for skin and soft tissue infections
• Safer space away from the dangers of drug scene (women)
• ↓ blood-borne infections*
• ↑ referrals and treatment initiation
• ↑ access to care
SUPERVISED CONSUMPTION SITES (SCS)

• Research to date (Potier et al., 2014; Kennedy et al., 2017)
  • ↓ of people injecting in public
  • ↓ discarded syringes and needles
  • ↓ in complaints
  • No increase in crime, violence or drug trafficking
  • No ↑ drug-related offenses over 10 years in Australia
  • Cost-effective (n=6)

In the present systematic review, we identified consistent, methodologically sound evidence demonstrating the effectiveness of SCS in achieving their primary health and public order objectives. Further, the available evidence does not support concerns regarding the potential negative consequences of establishing SCS, including that these promote drug use or attract crime. (Kennedy et al., 2017 p.177)
SUPERVISED CONSUMPTION SITES (SCS)

• Number of deaths in SCS in the world
2. HARM REDUCTION IS STANDARD OF CARE

- Not limited to drugs
  - Diet
  - Smoking
  - Drinking
  - Sex
  - Sports
  - Driving

- Not limited to a particular space
  - Hospital: nicotine patches when patients are hospitalized
  - Community: housing for people who experience homelessness
  - Clinic: pre-exposure prophylaxis for people who have unprotected sex
2. HARM REDUCTION IS STANDARD OF CARE

- Not limited to a population
  - Children
    - Ex: school cafeteria programs
  - Teenagers
    - Ex: safer sex education and condom distribution
  - Young adults
    - Ex: energy drink and binge drinking education
  - Adults
    - Ex: seatbelts and helmets
  - Elderly
    - Ex: fall prevention programs
2. HARM REDUCTION IS STANDARD OF CARE

HARM REDUCTION WORKS

↓ Harms
Funding

Pop specific programs
Public health campaigns
2. HARM REDUCTION IS STANDARD OF CARE

- Harm reduction is standard care *except for* people who use drugs.
- If it was standard of care, they would be able to:
  - Access safer drugs
    - Including prescribed diacetylmorphine and hydromorphone
  - Test their drugs
  - Access the supplies they need to inject, smoke, snort
  - Access supervised consumption services
  - Use with peers in supportive housing facilities
  - Get help to inject (i.e., assisted injection)
  - Access supplies and use during their admission in a hospital
  - Access supplies and use during their incarceration
  - Receive the care and support instead of being criminalized
3. HARM REDUCTION IS NOT ENOUGH

- Harm reduction and treatment as part of a continuum of care
  - Harm reduction increases likelihood of starting treatment
  - Harm reduction increases demand for treatment
- Access to treatment is imperative
  - Rapid access (ex: rapid access addiction clinic)
  - Regulated
  - Not-for-profit
  - Evidence-based
  - Low-barrier
  - Peers
  - Housing
  - Transition time
REFLECTIONS
1. REDUCING HARMS IN A HARM INDUCING CONTEXT

- Harm-inducing context
  - Not conducive to harm reduction
  - Barriers to care and services
  - Stigma and discrimination
  - Racism and oppression
  - Poor health and socioeconomic outcomes

In 2016, 73% of all drug arrests in BC were for drug possession

Source: Drug use, arrests, policing, and imprisonment in BC between 2015-2016 (2018)
1. REDUCING HARMS IN A HARM INDUCING CONTEXT

Figure 1: Adapted from Marks "The Paradox of Prohibition"
EXAMPLE: GOOD SAMARITAN LAW

- Became law on May 4, 2017
- Provides some legal protection for individuals who seek emergency help during an overdose
- Protects the person who seeks help, whether they stay or leave from the overdose scene before help arrives
- Also protects anyone else who is at the scene when help arrives
2. RESPONDING TO A TOXIC DRUG SUPPLY

- 72% of OD deaths in Canada related to fentanyl and analogues
- Example of the coroner report (Ontario)

### Appendix 3: Detection of opioids in toxicology results of opioid-related deaths

<table>
<thead>
<tr>
<th>Year</th>
<th>Jan to Apr 2017</th>
<th>May to July 2017</th>
<th>Aug to October 2017</th>
<th>Total Year to date 2017</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Total deaths</td>
<td>329</td>
<td>332</td>
<td>287</td>
<td>948</td>
<td>865</td>
</tr>
<tr>
<td>Fentanyl*</td>
<td>164</td>
<td>208</td>
<td>196</td>
<td>568</td>
<td>352</td>
</tr>
<tr>
<td>Carfentanil</td>
<td>4</td>
<td>10</td>
<td>25</td>
<td>39</td>
<td>39</td>
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<tr>
<td>Furanylfentanyl</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>6</td>
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<tr>
<td>Para-fluorobutyryl</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Despropionyl fentanyl</td>
<td>1</td>
<td>0%</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cyclopropyl fentanyl</td>
<td>1</td>
<td>0%</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>Heroin</td>
<td>45</td>
<td>46</td>
<td>41</td>
<td>132</td>
<td>78</td>
</tr>
<tr>
<td>U-47700</td>
<td>5</td>
<td>23</td>
<td>5</td>
<td>33</td>
<td>33</td>
</tr>
</tbody>
</table>
## 2. RESPONDING TO A TOXIC DRUG SUPPLY

<table>
<thead>
<tr>
<th>Province or territory</th>
<th>2016</th>
<th></th>
<th>2017</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>British Columbia</td>
<td>656</td>
<td>67%</td>
<td>1174</td>
<td>84%</td>
</tr>
<tr>
<td>Alberta</td>
<td>352</td>
<td>64%</td>
<td>567</td>
<td>79%</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>8</td>
<td>11%</td>
<td>9</td>
<td>22%</td>
</tr>
<tr>
<td>Manitoba</td>
<td>32</td>
<td>46%</td>
<td>42</td>
<td>49%</td>
</tr>
<tr>
<td>Ontario</td>
<td>330</td>
<td>45%</td>
<td>743</td>
<td>68%</td>
</tr>
<tr>
<td>Quebec</td>
<td>30</td>
<td>22%</td>
<td>25</td>
<td>15%</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>3</td>
<td>12%</td>
<td>8</td>
<td>24%</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>7</td>
<td>18%</td>
<td>6</td>
<td>10%</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>1</td>
<td>20%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>Suppressed</td>
<td>Suppressed</td>
<td>Suppressed</td>
<td>Suppressed</td>
</tr>
<tr>
<td>Yukon</td>
<td>4</td>
<td>80%</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>1</td>
<td>25%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Nunavut</td>
<td>Suppressed</td>
<td>Suppressed</td>
<td>Suppressed</td>
<td>Suppressed</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1424</td>
<td>55%</td>
<td>2679</td>
<td>72%</td>
</tr>
</tbody>
</table>

Suppressed – Data may be suppressed in provinces or territories with low numbers of cases. Please see Considerations and Limitations for more information.
3. RESTRICTING OPIOIDS NOT THE SOLUTION

• “Opioid chill”
  • College of Physicians and Surgeons of BC
  • Cannot limit dosage opioids or refuse to prescribe (or refuse patients)
3. RESTRICTING OPIOIDS NOT THE SOLUTION

- “Opioid chill”
  - Pushing people who suffer from pain to street drugs
CONCLUSION

• Lessons learned
  1. Overdose deaths are preventable
  2. Harm reduction is standard of care
  3. Harm reduction is not enough

• Reflections
  1. Reducing harms in a harm-inducing context
  2. Responding to a toxic drug supply
  3. Restricting access to opioids is not a solution
CONCLUSION

- As long as we criminalize drugs and people who use them, harm reduction will not work to its full potential.
- The fact that we treat people who use drugs as criminals is a:
  - Barrier to prevention
  - Barrier to care
  - Barrier to life-saving services
  - Driver of harms
    - Physical, mental, economic, social
  - Driver of the current crisis
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OPS_Resources

- Overdose Prevention Site Manual (Vancouver Coastal Health, 2016)
- This Tent Saves Lives (CAPUD, 2017)
- Good Samaritans vs. Bureaucrats: Which side are you on? (Pivot Legal Society and the Canadian HIV/AIDS Legal Network, 2017)
• Guidance on Community Consultation and Engagement Related to Implementation of Supervised Consumption Service (Dr. Peter Centre, 2017)
• Supervised Consumption Services: Operational Guidance (BCCSU, 2017)
• Implementing Supervised Injection Services (RNAO, 2018)
What is the effectiveness of supervised injection services? A Rapid Review (OHTN, 2014)

Supervised injection services: What has been demonstrated? A systematic literature review (Potier et al., 2014)

Public Health and Public Order Outcomes Associated with Supervised Drug Consumption Facilities: a Systematic Review (Kennedy et al., 2017)