Public Health Association of British Columbia
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October 30th, 2017

Open Letter to the Government of British Columbia:

BC Needs an OPIOID ACTION PLAN

Since April, 2016 when the epidemic of opioid overdose deaths was declared a 'Public Health Emergency' by the Provincial Health Officer for BC, a new government has been elected. A Ministry for Mental Health and Addictions has been created with a Minister appointed to lead the development of a response to the opioid issue with a $325 million budget.

The causes of this epidemic are complex:

- Large numbers of individuals and families with inadequate income, housing, food, employment, social supports, etc. who are living with hopelessness, stress and despair and dying more frequently from opioids, other drugs, alcohol, tobacco and violence.
- The promotion of opioids by pharmaceutical companies for pain relief and the willingness of physicians to prescribe them, coupled with inadequate resources for mental health, addiction treatment and non-opioid pain relief.
- Opioid and other substance use as self-medication for relief from stress and the effects of physical, emotional and sexual abuse.
- Street drug supplies in which fentanyl and analogues are ubiquitous and inconsistently mixed so that lethal doses are unavoidable. Fentanyl was detected in 80% of recent overdose deaths in BC.

While not all people who use drugs come from a background of deprivation, opioid addiction frequently begins and ends in desperation: homelessness, poverty, unemployment, crime, chronic poor mental and physical health, chronic physical and emotional pain and an untimely death. Therefore the broad issues of poverty, homelessness, food security, education, early childhood and youth development, employment and the other social determinants of health (SDOH) must be addressed in the plan.
We recommend a public health approach to this challenge: a comprehensive review of the issue and the generation of strategic interventions addressing the multiple causal factors.

In BC, we have a crisis: in Europe a rate of 2 overdose deaths/100,000 population /yr. is considered 'a major crisis' [1], the US is considered to have the highest overdose death rates in the world[2] at about 20/100,000[3]; BC is at 31/100,000[4] and Vancouver at 57/100,000[4], about 4-5 overdose deaths/day. (Vancouver is the epicentre for Canada; in the US, hotspots like Virginia have death rates as high as 90/100,000). "BC continues to experience unprecedented…overdose deaths and *more action is needed*"[5].

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Now we need a BC OPIOID ACTION PLAN to urgently address this crisis based on the following:

- **Destigmatize & decriminalize drug use and addiction** – people dependent on drugs should be treated with the same dignity and respect as patients suffering from any other chronic illness requiring clinical care (e.g. diabetes, heart disease), regardless of race, gender or age.
- **Security** - Provide people who are dependent on opioids with pharmaceutical opioids as part of the medical treatment of opioid addiction so they don't have to self-medicate with illicit street drugs contaminated with toxic ingredients; and they are brought into a comprehensive, secure and supportive therapeutic clinical setting as described below.
- **Economics** – it is cheaper to treat opioid addiction with appropriate clinical care and SDOH supports than to leave patients untreated, leading to much higher expenditures related to crime, violence, policing, courts, jails, prison, ambulances, ER visits, hospitalizations and so forth. Some estimates calculate about $35,000 per patient/year for treatment vs. as much as $100,000 per patient/yr. left untreated.

Coordinated action will be needed by all levels of government (federal, provincial and municipal) with/by Health Authorities:

The following actions are presented to be consistent with the 4 Pillars in the new Canadian Drug and Substances Strategy[6] **:**

Pillar 1: Prevention

Given that opioid addiction is a 'disease of despair' coordinated action is needed by all levels of government to address the SDOH (poverty and homelessness, etc.) and socioeconomic inequity through strategies with legislated goals, budgets and timelines.

Pillar 2: Harm Reduction

Many of these actions have been initiated but need expansion:

- Make Naloxone more available: 'take home' supplies and the expanded use of nasal spray format (for first responders uncomfortable with injections).

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- Explore and evaluate drug checking programs to establish the evidence for drug checking as an intervention to prevent overdoses and deaths.
- Expand the availability of supervised consumption (injection) services (SCS) for those continuing to use illicit street drugs.

- Explore, legislate and institute permanent Overdose Prevention Service (OPS) models, especially in settings which do not have the resources for full SCS.
- Expand the availability of non-opioid pain care services (non-opioid medications, myofascial release treatment, etc.)[7].

Pillar 3: Opioid Addiction Treatment

- Develop comprehensive, integrated **opioid addiction treatment centres** staffed with addictions specialists that include:
    - Baseline care with options for injectable or oral pharmaceutical opioids, including Suboxone, methadone, diacetylmorphine (heroin), hydromorphone (Dilaudid) and oral slow release morphine. Experience has shown that for most patients, Suboxone or methadone will meet their needs, but for a small minority these other options are required. Oral opioid antagonists such as naltrexone may also be considered. As these medications will be prescribed by physicians with addictions training, clinical judgement will ensure that the most cost-effective and appropriate medication will be prescribed.
      This approach is recommended for several reasons:
        - The provision of pharmaceutical opioids in a therapeutic setting has been shown in a number of jurisdictions to virtually eliminate infectious diseases (hepatitis and HIV) and overdose deaths related to opioid use (as patients are no longer consuming illicit street drugs contaminated with toxic materials such as fentanyl or infectious agents).
        - To maximize the goal of replacing the toxic illicit drug market as the primary source for people not yet in addiction treatment, pilot and evaluate several low threshold Public Health Access to Safer Opioids programs delivered through a wider array of points of service including clinics, community health centres and harm reduction programs.
        - When pharmaceutical opioids are widely available, the criminal street market is largely eliminated and much public expenditure avoided.
        - And when brought into a secure, supportive therapeutic setting these patients can be supported with SDOH interventions, counselling and so forth as below.
- SDOH supports for individual patients: income, housing, food, social support, education and others.

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- Integrated primary health care for treating co-morbidities (mental illness, chronic pain, hepatitis, HIV, cardiovascular disease, diabetes) and other addictions (alcohol, tobacco).
- Counselling and psychosocial supports (e.g. 12 steps) and supportive residential care to enable transition from opioid treatment with heroin, hydromorphone, etc. to methadone or Suboxone and, when possible, to abstinence.

- Training and education for employment such as peer counselling or as appropriate to past education, training and work experience.
- For some, eventual abstinence and return to family, community and work.

Pillar 4: Enforcement

Possession of small amounts of drugs for personal use should be decriminalized. Treating people as criminals contributes to their ongoing stigmatization and leads to social isolation and solo drug use without supportive peers and access to naloxone and other emergency measures and thus contributes to the epidemic of opioid deaths. Decriminalization can be implemented more quickly through local police procedural change and does not need the lengthy legal and legislative processes to achieve legalization of opioids.

- Opioid addiction treatment should be made available in all Corrections facilities.

The development of pain care and opioid addiction treatment teams will take some time and budget and will be best developed through a 'collective impact' approach at the local community level with funding from the Ministry for Mental Health and Addictions. Many of the Harm Reduction actions can be implemented quickly and help to immediately save lives. Developing poverty reduction and homelessness strategies will take more time but are of paramount importance to the long term solution of opioid addiction.

The above actions need to be supported by a better system of data collection, linkage, analysis, sharing and reporting, that allows the tracking (anonymous) of the therapeutic progress of patients (as has been done for HIV patients) so that the effectiveness of therapeutic interventions can be assessed. This will be critical to an **evaluation plan** that includes clinical outcomes, destigmatization measures and cost-effectiveness of programs to drive continuous quality improvement.

We are encouraged by the steps already taken by the BC and federal governments and BC Health Authorities and stand ready to assist in any way to quickly develop and implement an **OPIOID ACTION PLAN**.

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Respectfully,

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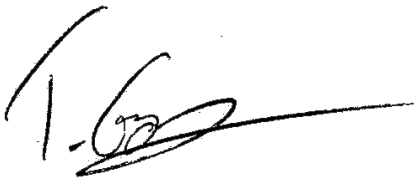
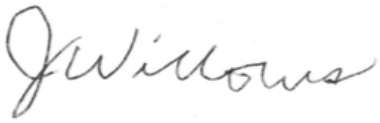
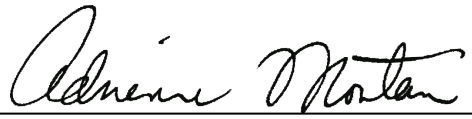
Seth Klein, Director
Canadian Centre for Policy Alternatives – BC Office



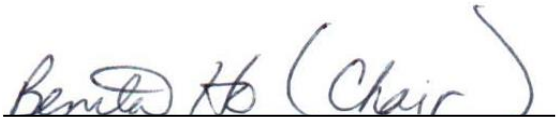
Trish Garner, Community Organizer
Poverty Reduction Coalition



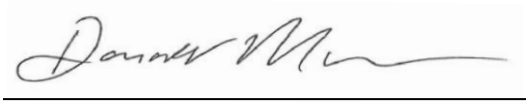
Judy Willows, Board of Directors
Community Legal Assistance Society



Adrienne Montani, Provincial Coordinator
First Call: BC Child and Youth Advocacy Coalition



Benita Ho, Chair
DTES Neighbourhood House



Donald MacPherson, Director
Canadian Drug Policy Coalition

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