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Fighting Fatality: Insight into British Columbia's Sanctioning of Overdose Prevention Sites

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Abstract

Due to the alarming rate of illicit drug toxicity deaths in British Columbia, a public health emergency was declared by Provincial Health Officer Dr. Perry Kendall on 14 April 2016. In response to the unsanctioned supervised consumption sites opened by concerned community members, and following the advice of Dr. Perry Kendall, Health Minister Terry Lake enacted a Ministerial Order in December 2016 to rapidly sanction overdose prevention sites. The Ministerial Order allowed regional health authorities the opportunity to provide overdose prevention services as necessary on an emergency basis for the duration of the public health emergency. The emergency sanctioning of overdose prevention sites enabled the BC government to take swift action to address the crisis while completing the lengthy and onerous application process for more permanent supervised consumption sites. The Ministerial Order allowed overdose prevention sites to operate without a strategic plan and prior community consultation. In May 2017, Parliament adopted Bill C-37, accepting a more streamlined application process for supervised consumption sites. Overdose prevention sites are an integral part of a multi-faceted solution to the opioid crisis, however, evaluation of the cost benefits and data reflecting the impact on first responders is wanting.

Face au taux alarmant de morts dues à la consommation de drogues illégales toxiques en Colombie Britannique, le médecin provincial en chef, Dr. Perry Kendall, a déclaré une situation d'urgence de santé publique le 14 avril 2016. En réaction à l'ouverture de sites sauvages de consommation supervisée par des membres actifs de la communauté, et suivant l'avis du Dr. Perry Kendall, le Ministre de la santé, Terry Lake, a pris un arrêté ministériel en Décembre 2016 pour valider rapidement les sites de prévention de surdose. L'arrêté ministériel autorise les autorités régionales à fournir les services de prévention de surdose autant que de besoin dans un contexte d'urgence et pour la durée de la situation d'urgence de santé publique. La validation d'urgence des sites de prévention de surdose a permis au gouvernement de CB d'agir rapidement pour résoudre la crise tout en faisant avancer le processus coûteux et lent d'accréditation de sites plus permanents de consommation supervisée. Le décret ministériel a autorisé les sites de prévention des surdoses à fonctionner sans plan stratégique ni consultation communautaire préalable. En mai 2017, le Parlement a adopté la loi C-37, établissant un processus simplifié pour la validation des sites de consommation supervisée. Les sites de prévention des surdoses sont un élément important de la solution à plusieurs facettes à la crise des opioïdes, mais il n'y a pas à ce jour d'évaluation des coûts et avantages ni suffisamment de données sur l'impact sur les premiers secours.

Key Messages

- In December of 2016, a Ministerial Order was issued by the BC Ministry of Health to sanction the implementation of overdose prevention sites in response to the opioid crisis.
- Overdose prevention sites are a low-barrier access point to supervised consumption services while health authorities fulfill the lengthy application process for more permanent supervised consumption sites.
- A cost-benefit analysis of a Vancouver supervised consumption site in 2009 revealed significant costs saved per prevented overdose death, but evaluation of the efficacy of overdose prevention sites to address the opioid crisis are wanting.

Messages-clés

- *En décembre 2016, un arrêté ministériel a été pris par le Ministre de la santé de CB pour autoriser l'ouverture de sites de prévention des surdoses en réponse à la crise des opioïdes.*
- *Les sites de prévention des surdoses sont un point d'accès aisé aux services de consommation supervisée, en attendant que les autorités mènent à leur terme les processus plus longs de validation des sites de consommation supervisée plus permanents.*
- *Une analyse coûts-avantages d'un site de consommation supervisée de Vancouver menée en 2009 a montré des économies significatives pour chaque surdose évitée, mais l'évaluation de l'efficacité des sites de prévention de surdose pour résoudre la crise des opioïdes reste à mener.*

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1 BRIEF DESCRIPTION OF THE HEALTH POLICY REFORM

The rate of illicit drug toxicity deaths in British Columbia (BC) increased substantially between 2012 and 2016 (BC Coroners Service 2019, 2). This increase was matched by an increase in fentanyl or its analogues being detected or suspected in 4% of illicit drugs in 2012, and in 67% of illicit drugs in 2016 (BC Ministry of Mental Health and Addictions 2019, 3). On 14 April 2016, a public health emergency was declared under the *Public Health Act* by Dr. Perry Kendall, BC's provincial health officer, in response to this alarming rise in opioid-related deaths (Province of British Columbia n.d.).

Following the declaration of a public health emergency, there was an increase in applications for federally sanctioned supervised consumption sites (SCS). The Government of Canada's website provides the following information on SCS:

> SCS are part of our harm reduction approach to the Canadian drugs and substances strategy. This is because Canadian and international evidence shows clearly that they help to save lives and improve health... SCS are cost effective and do not increase drug use and crime in the surrounding area.
>
> SCS are an entry point to treatment and social services for people who are ready to stop or reduce their use of substances...
>
> They provide [among other things]:
>
> - a safe, clean place to consume illegal substances (Government of Canada 2018).

In December 2016, due to an increased need for emergency interventions, and in response to unsanctioned "pop up" injection sites run by community activists (Wallace, Pagan, Pauly 2019, 65), the BC Minister of Health enacted a Ministerial Order to rapidly sanction overdose prevention sites (OPS). OPS are low-barrier, temporary facilities sanctioned to operate only throughout the duration of the opioid crisis. The goal of OPS is to provide supervised consumption services to reduce overdose deaths, but they "do not generally have the additional services or goals of a SCS. These include connecting people with other health and social services" (Government of Canada 2018).

2 HISTORY AND CONTEXT

2012-2016: Mortality caused by illicit drug toxicity in BC increased from 270 deaths in 2012 to 529 deaths in 2015. From January-March 2016 alone, 219 deaths were caused by illicit drug toxicity (BC Coroners Service 2019, 3).

April 14, 2016: Provincial Health Officer Dr. Perry Kendall declares a public health emergency under the *Public Health Act* due to the significant rise in opioid-related overdose deaths in BC. Declaring a "public health emergency under the Act allows for real-time information to be collected, reported and analyzed across the health system, to identify immediately where risks are arising and take proactive action to warn and protect people who use drugs" (Province of British Columbia n.d.).

July 2016: Premier Christy Clark appoints a Joint Task Force on Overdose Response, headed by Provincial Health Officer Dr. Perry Kendall and Director of Police Services Clayton Pecknold. The task force "[provides] expert leadership and advice to the Province on additional actions to prevent and respond to overdoses in [BC]" (*BC Gov News* 2016).

December 2016: BC Coroners Service confirms approximately 991 overdose deaths in 2016 (BC Coroners Service 2020, 3). This resulted in a push for scale up of SCS and led to an increase in the number of applications for federal approval.

December 2016: In response to the growing number of overdose deaths and emergence of unsanctioned OPS, the BC Minister of Health enacts a Ministerial Order as part of the declared public health emergency to rapidly sanction OPS as "an extraordinary measure to respond to the overdose crisis" (Wallace, Pagan, Pauly 2019, 65). This Order directs regional health authorities to set up overdose prevention services as "ancillary health services" for the purpose of monitoring persons at risk of overdose and providing rapid intervention (Lake 2016).

3 GOALS OF THE REFORM

3.1 Stated

The primary goal of this reform was to prevent overdoses. Urgent action was prompted by "the alarming rate of overdoses combined with the onset of colder weather" (*BC Gov News* 2016). The stated goal of the OPS was to "make sure that people have access to people trained to respond should an overdose occur" (*BC Gov News* 2016). The Order provided BC Emergency Health Services and regional health authorities the ability to provide overdose prevention services as necessary on an emergency basis. Each health authority is responsible for assessing the need in their region and providing these services in a "manner consistent with federal legislation" (*BC Gov News* 2016).

3.2 Implicit

The implicit goals of this reform were political in nature. The provincial and federal governments were under scrutiny due to the rise in opioid-related deaths and the continued bureaucratic barriers faced by those applying to open SCS (Tsang 2020). Bureaucratic barriers included those imposed by Bill C-2, which was introduced by the federal government

in October 2013 (Kazatchkine, Elliot, MacPherson 2014, 3). Bill C-2 required those applying for exemptions under section 56 of the *Controlled Drugs and Substances Act* to operate SCS "to submit an onerous amount of information to the federal Minister of Health before (s)he may even consider an application for an exemption. . . [and] exemptions will only be granted in 'exceptional circumstances' " (*Ibid.*, 3).

In 2016, following 175 overdoses in a five-day period in Vancouver's Downtown Eastside, activists and nursing professionals began operating two illegal pop-up tents on the streets, offering "clean needles, food and basic medical care" to people in immediate need (Brend 2016). These unsanctioned "pop up" supervised injection sites were an effort by community members and healthcare workers to take matters into their own hands where they felt the government was failing to address the crisis (*Ibid.*). Marilou Gagnon, the "founder of a coalition of nurses and nursing students pushing for more supervised injection sites," asserted that health workers were too busy as a result of the crisis to advocate for the declaration of the opioid-related deaths as a national crisis (*Ibid.*). She called "on nursing associations and advocates to get louder" (*Ibid.*).

The Ministerial Order (Lake 2016) sanctioning rapid implementation of OPS was the Ministry of Health's response to the public's concerns and to the emergence of unsanctioned overdose prevention sites (Wallace, Pagan, Pauly 2019, 65). This response is an escalated measure to address the overwhelming losses to the opioid crisis in BC, providing an emergency intervention "while waiting for federal approval of SCSs" (*Ibid.*, 65).

4 FACTORS THAT INFLUENCED HOW AND WHY

4.1 The issue came onto the government's agenda

In the months prior to the public health emergency declaration (January-March 2016), 219 people died of illicit drug toxicity, which is nearly as many people who died of illicit drug toxicity in all of 2012 (270 deaths) (BC Coroners Service 2019, 3). The government's response to the crisis was to declare a public health emergency in order to collect data to identify immediate risks and to "take proactive action" (Province of British Columbia n.d.). However, "members of the public did not find the government's actions proactive enough, and unsanctioned SCS were implemented by concerned community members and healthcare workers who were frustrated by the 'red tape and [bureaucracy]' " involved in opening sanctioned SCS (Brend 2016).

The Joint Task Force on Overdose Response released its second progress update in November 2016. This report echoed concerns of the activists driving the unsanctioned injection sites regarding the barrier caused by the federal government's failure to repeal or amend its legislation and allow for quicker deployment of supervised consumption services (Joint Task Force on Overdose Response 2016, 8).

4.2 The final decision was made

Taking the advice of Dr. Perry Kendall, Health Minister Terry Lake enacted the Ministerial Order to sanction the development of OPS in areas of need (Lake 2016). The decision to finally enact the Ministerial Order in December 2016 was in response to approximately 830 fatal overdoses in BC from January to the end of November 2016 (BC Coroners Service 2020, 3). While the federal government was beginning to make changes to "make it easier to set up supervised-drug-injection sites as part of its approach to fighting a dramatic rise in overdoses across the country" (Omand 2016), Lake stated that BC could not wait and had to act more urgently to "alleviate pressure on first responders" (*Ibid.*).

The Joint Task Force's November 2016 report notes the support for SCS by local governments in BC. Premier Christy Clark announced "$10 million in funding to assist regional health authorities in developing [supervised] consumption services" (Joint Task Force on Overdose Response 2016, 8). Despite the support by BC government leaders, the legislative barriers at the federal level remained. Implementation of more permanent SCS would continue to be delayed due to the "extensive application process for the exemption" (*Ibid.*, 8; Tsang 2020). While health authority applications for SCS continued (*BC Gov News* 2016), the implementation of OPS allowed the BC government to take immediate action when faced with federal impediment. The Ministerial Order allowed Terry Lake to legally implement OPS for the duration of the public health emergency despite the barriers imposed by Bill C-2 (*BC Gov News* 2016).

5 HOW THE REFORM WAS ACHIEVED

OPS are sanctioned for the duration of the ongoing public health emergency. Around 20 OPS opened within a few days to months of the Ministerial Order's enactment (Wallace, Pagan, Pauly 2019, 65). The Order allowed OPS to open swiftly without the same barriers faced during SCS applications. Furthermore, it enabled OPS staff to work without "risk of reprisal" (*Ibid.*, 67), and permitted OPS to open without a strategic plan, policies and procedures, and community consultation (*Ibid.*, 67-68). Regional health authorities are responsible for determining the need for OPS in their region and establishing them where necessary (*BC Gov News* 2016).

On 13 October 2016, the *Health Professions Act* [RSBC 1996] and the *Emergency Health Services Act* [RSBC 1996] were amended to allow all healthcare providers, first responders and citizens to administer naloxone outside of a hospital setting (BCCDC 2016, 1; Crowell 2019, 4). These amendments, paired with the Ministerial Order, allowed those witnessing an overdose, whether in public or in a supervised injection facility, to intervene without risk of legal retribution.

6 EVALUATION

Evaluation of the efficacy of OPS to address the opioid crisis has been limited but conclusive. Wallace, Pagan, Pauly (2019) conducted research to assess the initial implementation of OPS. Their research involved three OPS in Vancouver but was limited to the early implementation phase. Wallace *et al.* identified that OPS are "community-driven" and involve people who use drugs in "service design, implementation and delivery" (*Ibid.*, 71). They observed the temporary nature of OPS due to funding being limited to the duration of the public health emergency. Wallace *et al.* identified an opportunity to establish OPS as "primary points of contact and entry into the health system and as part of an ongoing system of substance use services"(*Ibid.*, 71).

Irvine and colleagues evaluated the combined impact of three "opioid overdose interventions implemented in BC between April 2016 and December 2017 on the number of deaths averted" (2019, 1602). Irvine *et al.* confirm that "to date, few studies have examined decrease in mortality due to [SCS], and no studies have examined the benefits of OPS" (Irvine *et al.* 2019, 1603-1604). Their findings identify that "[t]o be successful, the public health response must be multi-faceted, rapid and responsive, and must reduce the numbers of overdoses and deaths, as well as address the root psychological and social causes of the crisis" (*Ibid.*, 1609).

Irvine *et al.* estimated the total impact of OPS/SCS to be 230 (160-350) death events averted between April 2016 and December 2017 (*Ibid.*, 1609). "To date, not a single overdose death has occurred at an OPS or SCS. The OPS/SCS programme has therefore already substantially reduced mortality and its long-term impact is likely to be very significant" (*Ibid.*, 1609).

The BC Ministry of Mental Health and Addictions reports that "despite escalated efforts across the province, British Columbians continue to experience unprecedented rates of overdose-related harm including death due to an unregulated drug supply that is unpredictable and highly-toxic." The BC Coroners Service reports that at least 1,544 people died from confirmed or suspected drug toxicity in 2018, an increase from 1,495 in 2017 and 991 in 2016 (BC Coroners Service 2020, 3). "The rate of fentanyl-detection in confirmed or suspected drug toxicity deaths has increased from 4% in 2012 to 83% in 2019" (BC Ministry of Mental Health and Addictions 2019, 2).

Between January and June 2019, 543 people died from confirmed or suspected drug toxicity (BC Coroners Service 2020, 3). This is a 29% decrease compared to the same period in 2018 (BC Ministry of Mental Health and Addictions 2019, 2). The BC Ministry of Mental Health and Addictions also references Irvine *et al.*'s 2019 findings, which reveal that approximately "3030 death events were averted between April 2016 and December 2017 due to the improved access to naloxone, supervised consumption and overdose prevention services, and opioid agonist treatment" (*Ibid.*, 4). "Without these life-saving interventions, it is likely that the number of overdose deaths would have been 2.5 times greater during this period" (*Ibid.*, 4-5). Data reflecting the number of lives saved as a result of improved

access to OPS/SCS should be collected, and these indicators should be shared regularly with the public (specifically, members living in communities surrounding OPS/SCS) in order to address the stigma surrounding safe injection sites.

OPS in BC had around 550,000 visits and 2,500 non-fatal overdoses in their first year of operation (Wallace, Pagan, Pauly 2019, 65). The percentage of illicit drugs with fentanyl or its analogues detected has rapidly increased since 2016, indicating the need for a multi-faceted approach (Irvine *et al.* 2019, 1609), of which OPS/SCS are an integral component.

Evaluation of the cost-benefits of OPS are wanting. While a cost-effectiveness analysis of Vancouver's SCS, Insite, published in 2009, found that the costs saved per prevented overdose death was $660,000 (Andresen and Boyd 2009, 72), evaluation since the rise in opioid deaths is lacking. Data reflecting the number of overdoses first responders are attending in the communities surrounding OPS/SCS are also minimal. Data should be collected at the provincial level comparing the number of paramedic responses to overdoses surrounding OPS/SCS occurring during operating hours versus after hours. This data would inform whether there is a need for extended OPS/SCS operating hours.

The alarming rise in opioid-related deaths in Canada (particularly in BC) and the resulting "pop-up" supervised consumption sites, which disregarded the federal *Controlled Drugs and Substances Act*, resulted in the federal government adopting Bill C-37 (Canadian HIV/AIDS Legal Network 2017, 3). Bill C-37, which received Royal Assent on 18 May 2017, reduced the application criteria for SCS from 26 to 8, thereby lessening the barriers to approval of SCS (Government of Canada 2017; Tsang 2020). The federal government recognized that unsanctioned supervised consumption sites, "operating despite the legal risk of prosecution of service-users and staff/volunteers" (Canadian HIV/AIDS Legal Network 2017, 3), were a necessary response to opioid-related deaths in Canada. Federal Health Minister Jane Philpott voiced support of BC's Ministerial Order (Omand 2016), and the federal adoption of Bill C-37 (Government of Canada 2017) speak to the recognized impact of OPS and a streamlined application process for SCS.

While the federal government has come a long way since Bill C-2 (2013), data should be collected and shared regularly by Health Canada to educate the public on the efficacy of harm reduction approaches. While OPS were implemented without community consultation (Wallace, Pagan, Pauly 2019, 65) due to the Ministerial Order, they are only sanctioned for the duration of the public health emergency (*Ibid.*, 65). Community consultation continues to be an integral component of the SCS application process (Government of Canada 2017). It is crucial that the federal government continues to educate the public on the specific impact of OPS and SCS on the opioid crisis to reduce the lengthy community-consultation component of the SCS application process. If the Canadian public is educated about the impact of SCS on reducing mortality rates, costs saved per prevented overdose death, and the reduced impact on first responders and hospitals, citizens being consulted about the establishment of an SCS in their community may be more likely support its implementation.

7 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Table 1: SWOT analysis of overdose prevention sites

Strengths	Weaknesses
• Swift implementation. • Low-barrier entry to health services for people who use drugs. • Drug testing provided at OPS to test for fentanyl and its analogues as its detection in the illicit drug supply rises. • No overdose deaths at OPS/SCS in Canada.	• Temporary and only funded/sanctioned for the duration of the public health emergency. • Provide limited access to other health and social services. • Besides offering drug testing, OPS cannot address the increase in fentanyl and its analogues in illicit drugs. • OPS/SCS currently do not operate 24/7.
Opportunities	**Threats**
• Likely reduction in need for first responders in areas surrounding OPS/SCS during operating hours. • Novel approach to staffing sites with peer workers and people with lived experiences. • Further legislative changes to allow OPS to operate beyond the public health emergency in areas of need. • Cost-benefit evaluation of OPS/SCS since the public health emergency was declared could garner stronger public support.	• Stigma of community members who live in areas surrounding OPS/SCS. • OPS success relies on the input of those who use services. SCS bureaucratic application process does not allow the same opportunity for user engagement.

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9 FOR MORE DETAIL

9.1 General information

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