

Case Studies from Four Canadian Clinics

The Urgent Need for Expanded Response Options



Canada is facing an urgent challenge to reduce the harms associated with the problematic use of opioids. More than 14,700 lives were lost to deaths apparently related to opioids between January 2016 and September 2019. During that same period, there were 19,490 hospitalizations for poisoning related opioid to opioids (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2019). The COVID-19 pandemic compounds this ongoing public health crisis. There is a heightened need to reduce avoidable pressures on healthcare systems and support people who use opioids who may be at increased risk or unable to self-isolate during the pandemic.

Individuals using opioids need a range of comprehensive, accessible, quality services to support them if they choose to reduce or stop, but available treatment options are limited. Many individuals with lived or living experience, as well as public health and medical professionals, are calling for pharmaceutical-grade

KEY MESSAGES

- The COVID-19 pandemic continues to compound the ongoing public health crisis related to high rates of opioid overdoses and deaths.
- Access to a greater range of pharmaceutical treatment options for opioid use can substantially improve the likelihood that clients remain in treatment, improve the quality of life for people who use opioids and help reduce deaths from a contaminated illicit opioid supply.
- Fully responding to opioid harms requires addressing fundamental problems of regulated and safer supply and mental health, trauma and the social determinants of health.
- Recent legislative changes in Canada have increased the availability of diacetylmorphine and hydromorphone, two pharmaceutical treatment options for opioid use disorder. Additional class exemptions issued by Health Canada in the context of COVID-19 have further reduced barriers to accessing pharmaceutical options.
- Response needs to involve collaborative decision making involving people with lived or living experience of opioid use, who are well positioned to anticipate unintended consequences and identify effective solutions.
- There is a need to support physician and pharmacist competency and engagement, as they play a pivotal role in moving toward broader implementation of expanded options.

opioids to be made available to treat persons with opioid use disorder (OUD), and to stem the deaths occurring from the contaminated illicit opioid supply (Canadian Community Epidemiology Network on Drug Use, 2020).

There is evidence that injectable hydromorphone or diacetylmorphine therapies are viable treatment options for patients with severe OUD (Fairbarin et al., 2019). Further, administering these therapies in primary care clinics and designated



“I don’t think harm reduction is different than recovery. It’s all about someone just living their best life and being happy and meeting their goals and whether or not they use drugs I think is irrelevant. ... we want people to be alive, not get HIV, and live with joy in their life with other human connections, and that’s what these programs do. And whether or not you call that recovery is up to you.”

— *Christy Sutherland, MD, Portland Hotel Society, Vancouver and Victoria*



pharmacies is feasible and cost efficient. This integration can provide the opportunity to address additional primary care needs in parallel, potentially leading to positive short-term outcomes such as stopping illicit opioid use, reducing criminal activity and transitioning into stable housing and employment (Wilson, Brar, Sutherland, & Nolan, 2020).

Comprehensive efforts have been made across the country to address the multiple factors contributing to the opioid crisis and minimize ongoing harms, with some strategies more widely implemented than others. For example, naloxone, an emergency measure that can reverse an overdose, has become widely available across Canada (Moustaqim-Barrette et al., 2019). In contrast, the availability of opioid agonist therapies (OAT) can vary by jurisdiction and region, as well as with physician competence (Herring, Lefebvre, Stewart, & Selby, 2014; Taha, 2018).

While these case studies highlight injectable OAT options, providing an array of flexible options for delivery and administration of treatment during the pandemic can support people who use opioids by reducing the risk of overdose, infection and withdrawal while they maintain physical distancing or must self-isolate. Health Canada has recently issued a [class exemption](#) under subsection 56(1) of the

[Controlled Drugs and Substances Act](#) that increases the accessibility of controlled substances for therapeutic purposes (Health Canada, 2020), and British Columbia has issued [interim clinical guidance](#) for putting these exemptions into place (British Columbia Centre on Substance Use, 2020).

This resource provides case studies of the expanded response options to opioid harms used by four Canadian clinics in 2019. These case studies are intended to share information and generate discussion about alternative complementary measures for improving the quality of life of people who use opioids, especially those with severe OUD, and the value of implementing expanded responses to reducing opioid harms. The resource is intended



“We try to optimize their treatment as best we can, but some participants really feel like substance use is a part of who they are and at this moment they are not going to stop the use, and that’s okay, too. So, they can still come here, it’s not that they are going to be stigmatized or removed from the program because of their ongoing substance use and it’s sort of like trying to have harm reduction and treatment coincide with each other, that they are not these opposing ideas, that they can actually exist together.”

— *Tara O’Mara, NP, Alberta Health Services, Edmonton*



ACKNOWLEDGEMENTS

We are grateful to the following participants who offered their time and shared their experience for the case studies:

- Scott MacDonald, MD, Providence Healthcare, Vancouver
- Tara O’Mara, NP, Alberta Health Services, Edmonton
- Christy Sutherland, MD, Portland Hotel Society, Vancouver and Victoria
- Jeffrey Turnbull, MD, Ottawa Inner City Health, Ottawa

for a broad audience including mental health and addiction service providers, harm reduction service providers, primary care and clinic physicians and nurses, first responders, pharmacists, policy makers, researchers and people who use drugs. The case studies were conducted before the onset of the COVID-19 pandemic. Since then, in response to the need for social isolation, a greater flexibility in response options is being explored in Canada and many other countries around the world.

Key Learnings for Injectable Opioid Therapy



The four clinics that provided information for this report are profiled below. The small sample means it is not possible to draw general conclusions. Furthermore, the distribution of participants

across Canada was not equal and the findings may not be representative of experiences in all regions. Nevertheless, the case studies shine a spotlight on Canadian examples of current practice for expanded options to address OUD. The findings from practice were supplemented with those from the literature:

- The case study participants identified low-barrier access to treatment, open-ended time for physician engagement and ongoing evaluation of treatment

CLINIC PROFILES

Four clinics were contacted for this study. Three are outpatient clinics and one is a residential program. Clinics are located in Alberta, British Columbia and Ontario. Their treatment services integrate harm reduction approaches and place them on a single continuum of care. Some patients use the clinics or program as an avenue for “safer supply.”

Each clinic or program supports 20–150 individuals, depending on capacity. Patients of the clinics or program must meet the following criteria:

- Use drugs intravenously
- Be diagnosed with OUD
- Be at risk of overdose
- Have a history of unsuccessful oral treatment

Patients enter the clinics and programs via:

- Self-referral
- Referral from other clinics and programs
- Connection through supervised consumption sites

The clinics and programs offer a variety of medical response options to opioid harms that include:

- Preloaded syringes of hydromorphone provided for client to inject while supervised or for nurse to assist (80–630 mgs over 3–6 doses per day)
- Hydromorphone tablets crushed by nurses and sterile injectable equipment provided to patients to administer (16 mgs, up to five times per day)
- Preloaded syringes of diacetylmorphine provided to client for supervised injection or for a nurse to assist (up to 400 mg in three doses per day to a maximum daily dose of 1,000 mg)

The clinics offer the following additional services:

- Primary care
- HIV and hepatitis C treatment
- Women’s health
- Chronic disease management (e.g., chronic obstructive pulmonary disease, hypertension)
- Psychiatry
- Social work
- Peer support
- Nutrition education
- Pharmacy
- Connections
 - Housing
 - Employment services

Clinics report the following outcomes:

- Improved health, hygiene and nutrition
- Reconnection with family
- Employment
- Engagement in leisure activities
- Decreased criminality
- Fewer or no overdoses
- Connections with other services
 - Psychiatry
 - Initiation of HIV or hepatitis C treatment
 - Housing support



“We already have evidence that injectable hydromorphone is safe, and both more effective and more cost-effective in that population that continues to inject despite attempting oral treatments. But now we also know that it reduces mortality. It needs to be available and it will be available.”

— *Scott MacDonald, MD, Providence Healthcare, Vancouver*

programs as key factors for success.

- An additional success factor of including people with lived or living experience in decision making to determine appropriate responses, identify effective solutions and anticipate unintended consequences is supported by the literature (Taha, Maloney-Hall, & Buxton, 2019).
- The case studies demonstrate that quality of life for people who use opioids can be substantially improved across multiple dimensions by providing access to a greater range of pharmaceutical treatment options.
- It remains essential to address underlying problems related to mental health conditions, trauma and the social determinants of health in support of the response to opioid harms (Canadian Centre on Substance Use and Addiction, 2017).
- Policy levers, such as those addressing physician remuneration and billable time for engagement, can help move the identified factors for success forward (Childerhose, Atif, & Fairbank, 2019).
- Participants noted that addressing privacy restrictions that inhibit information sharing among clinics and programs could be a further contributor to success.
- Injectable opioid agonist therapy can be safely transitioned to a

designated community pharmacy upon dose stabilization (Wilson et al., 2020).

- Challenges to program delivery identified by the case study participants include reliable funding for medications and staffing, harms to clients who use substances other than opioids and opposition to using expanded response options from colleagues, other healthcare services or correctional facilities.
- The case study respondents reported that men tended to access the clinics and programs more than women. Some women, particularly those involved in the sex trade, or those who prefer assisted injection or want to inject in an area that they do not want to expose (such as their chest), are uncomfortable or feel threatened in the presence of men.



“We need to know what the values, goals and individual plans are for each patient. It does need to be individualized, and there needs to be opportunity for shared care. That may include, well, which drug do you want? Would you prefer diamorphine or hydromorphone? We should be respecting people’s decisions. When somebody is ready to transition to oral, then, how would you like to do that? Do you want to do micro dosing with Suboxone? Do you want to try methadone? A taper or Kadian? We give people choice.”

— *Scott MacDonald, MD, Providence Healthcare, Vancouver*

Practice Implications



Considerations for Implementation

The social distancing required as part of the response to the COVID-19 pandemic has forced policy makers to create new guidelines to ensure programs continue to support people with lived and living experience while respecting these requirements. These new practices will need to be revisited and evaluated to identify practices to continue post-pandemic.

The case study participants proposed the following considerations for implementing expanded response options, depending on the needs of the community:

- Family doctors could work with their community pharmacy to ensure expanded response options are available at their clinics.
- After developing a relationship with a person who uses opioids,



care providers may wish to consider if there are opportunities to connect them to additional external services.

- Specialized services may be needed in some communities to address particular population concerns.

Participants noted additional solutions to help improve quality of care:

- Provide women-only programs;
- Produce diacetylmorphine domestically to improve access;
- Increase the capacity of programs to accommodate more patients; and
- Develop take-home programs to minimize the toll on patients' and services providers' time.

Supports for Physician Competence

The case study participants noted that physicians might not feel fully confident in this aspect of their practice because of the need for holistic skills encompassing addiction, mental health and public health expertise. They explained that physician competence typically develops over time, but also suggested the following supports for physicians to improve their competence:

- Regularly review the literature;
- Respond to calls for change in practice;
- Attend physician training courses;
- Use point-of-care modules; and
- Find opportunities for mentorship and access to specialist supports.

Evaluation and Knowledge Mobilization

Evaluation of the impact of these programs, including a focus on unique implementation needs for particular populations and programs, will contribute to the evidence base. Continued knowledge mobilization

of the outcomes achieved by people accessing these clinics and programs is necessary to propel discussion about the value of implementing expanded responses to opioid harms.

Conclusion and Next Steps



These case studies profile the expanded response options to opioid harms used by four Canadian clinics. The intent is to fuel discussion about alternatives for improving the quality of life for people who use opioids and the value of expanded responses to reducing opioid harms. This discussion is particularly important during the COVID-19 pandemic, which is compounding the ongoing public health crisis of opioid overdoses and deaths. The lessons learned from these case studies can inform efforts to implement expanded response options for opioid harms. These efforts could include:

- Expanding the scope of treatment options available due to the

urgent need to respond to the COVID-19 pandemic and evaluating the impact of these changes in practice to determine what could be sustained after the pandemic;

- Supporting the implementation of identified good practices and trialing solutions to recognized problems, including finding ways to address fundamental problems related to underlying mental health conditions, trauma and the social determinants of health;
- Supporting physicians to develop competence in delivering these treatments through literature reviews, training, point of care models, and mentorship and specialist supports;
- Rigorously investigating the effectiveness of these types of programs and the improvements they claim through randomized control trials and program evaluation; and
- Broadly sharing new knowledge with policy makers, researchers, the full range of potential service providers, and persons who use substances and their supporters and allies.



“In a supervised injection site, the immediate goal is safety, getting the chaos out of their life, connecting with other things that are important for their addiction management, such as a psychiatrist, counselling, family, employment, leisure.... we watch them inject, and they overdose, and we give them Narcan, and we send them on their way, only to do it again. If we [can] stabilize them, keep them alive, and then work on their addiction, that seem[s] to be a much more effective strategy. And yeah, if we could get them to oral, that would be fantastic. If we could get them abstinent, working, all of those things, that would be fantastic too. But really, it's not my objectives. It's theirs.”

— *Jeffery Turnbull, MD, Ottawa Inner City Health, Ottawa*





Additional Resources

- Canadian Centre on Substance Use and Addiction, [Impacts of COVID-19 on Substance Use](#)
- Canadian Centre on Substance Use and Addiction, [Opioids](#)
- Health Canada, [Subsection 56\(1\) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada during the coronavirus pandemic](#)
- Health Canada, [Opioid Symposium: What We Heard Report](#)
- Health Canada, [Toolkit for Substance Use and Addictions Program Applicants. Stream 2 – Increase access to pharmaceutical grade medications](#). Available upon request from hc.SUAP-PUDS.sc@canada.ca with “Safe Supply Tools” in the subject line.
- Canadian Research Initiative in Substance Misuse (CRISM), [National Guideline for the Clinical Management of Opioid Use Disorder](#)
- CRISM, [COVID-19 Pandemic – National Rapid Guidance](#). CRISM provides six national guidance documents that address the urgent needs of people who use substances, service providers and decision makers in relation to the COVID-19 pandemic. (Some documents forthcoming and yet to be provided in French.)
- Centre for Health Evaluation and Outcome Sciences, [Evidence Summary: Dextroamphetamine Sulfate \(Dexedrine spansule\) for the Treatment of Stimulant Use Disorder](#)
- Public Health Ontario, [Effectiveness of Supervised Injectable Opioid Agonist Treatment \(SiOAT\) for Opioid Use Disorder](#)
- Safer Opioids Supply Programs, [A Harm Reduction Informed Guiding Document for Primary Care Teams](#)
- British Columbia Centre on Substance Use, [Guidance for Injectable Opioid Agonist Treatment for Opioid Use Disorder](#)
- CRISM, [Injectable Opioid Agonist Treatment Guideline](#)
- Health Canada, [Toolkit: COVID-19 and Substance Use](#). Available upon request from hc.cdss-scdas.sc@canada.ca
- Canadian Association of People Who Use Drugs, [Safe Supply Concept Document](#)
- Canadian Family Physician Clinical Practice Guidelines, [Managing Opioid Use Disorder in Primary Care: PEER Simplified Guideline](#)





References

- British Columbia Centre on Substance Use. (2020). COVID-19 resources. Retrieved from <https://www.bccsu.ca/covid-19/>
- Canadian Centre on Substance Use and Addiction. (2017). *Moving toward a recovery-oriented system of care: A resource for service providers and decision makers*. Ottawa: Author.
- Canadian Community Epidemiology Network on Drug Use. (2020). *Adulterants, contaminants and co-occurring substances in drugs on the illegal market in Canada*. Ottawa: Canadian Centre on Substance Use and Addiction.
- Childerhose, J., Atif, S., & Fairbank, J. (2019). *Family physician remuneration for substance use disorders care*. Ottawa: Canadian Centre on Substance Use and Addiction. Retrieved from <https://www.ccsa.ca/family-physician-remuneration-substance-use-disorders-care>
- Fairbarin, N., Ross, J., Trew, M., Meador, K., Turnbull, J., MacDonald, S., . . . & Sutherland, C. (2019). Injectable opioid agonist treatment for opioid use disorder: a national clinical guideline. *Canadian Medical Association Journal*, 191(38), E1049–1056.
- Health Canada. (2020). *Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada during the coronavirus pandemic*. Ottawa: Government of Canada.
- Herring, R. D., Lefebvre, L. G., Stewart, P. A., & Selby, P. L. (2014). Increasing addiction medicine capacity in Canada: The case for collaboration in education and research. *Canadian Journal of Addiction*, 5(3), 10–14.
- Moustaqim-Barrette, A., Elton-Marshall, T., Leece, P., Morissette, C., Rittenbach, K., & Buxton, J. (2019). *Environmental scan: Naloxone access and distribution in Canada*. Vancouver: Canadian Research Initiative in Substance Misuse.
- Special Advisory Committee on the Epidemic of Opioid Overdoses. (2019). *Opioid-related harms in Canada*. Ottawa: Public Health Agency of Canada. Retrieved from <https://health-infobase.canada.ca/substance-related-harms/opioids>
- Taha, S. (2018). *Best Practices across the continuum of care for the treatment of opioid use disorder*. Ottawa: Canadian Centre on Substance Use and Addiction.
- Taha, S., Maloney-Hall, B., & Buxton, J. (2019). Lessons learned from the opioid crisis across the pillars of the Canadian drugs and substances strategy. *Substance Abuse Treatment, Prevention, and Policy*, 14(1), 32.
- Wilson, T., Brar, R., Sutherland, C., & Nolan, S. (2020). Use of a primary care and pharmacy-based model for the delivery of injectable opioid agonist treatment for severe opioid use disorder: A case report. *Canadian Medical Association Journal*, 192, E115–E117.

