Community Response to Opioid Harms: Considerations for Supervised Consumption Sites

TO:	Chair and members of the Board of Health
MEETING DATE:	March 7, 2018
REPORT NO:	**BH.01.MAR0718.R06** Pages: 11
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Recommendations

It is recommended that the Board of Health:

- **Receive this report for information**.

Key Points

- Wellington-Dufferin-Guelph Public Health (WDGPH) and community partners are working together to develop a coordinated and comprehensive approach to reduce opioid-related harms. WDGPH provides local surveillance data, evidence and best practices to inform the development of a community response.
- Due to growing concerns about opioid-related deaths and harms across Ontario, there has been increased interest in Supervised Consumption Sites/Services/Facilities (SCS) throughout the province.
- SCS is a broad term for providing sterile equipment and a safe and hygienic environment for people to use pre-obtained illicit substances under the supervision of trained service providers, peers or health care professionals without the fear of arrest or accidental overdose. There are different types of SCS, which are discussed further in the report. Currently in Ontario, the Ministry of Health and Long-Term Care (MOHLTC) is funding temporary Overdose Prevention Sites (OPS).
- Extensive literature has demonstrated that SCS reduce overdose mortality, reduce syringe sharing, reduce public injecting and dropped syringes and enhance uptake of health, social services and addictions treatment. SCS have not been shown to increase or decrease local crime, violence, drug-trafficking or local rates of injection drug use.

- Communities who have implemented and conducted research on SCS have been larger urban cities with an established drug-scene. To date, there is a lack of evidence regarding the impact of SCS in smaller communities such as Wellington, Dufferin and Guelph (WDG).
- This report outlines background information and evidence for the impact of SCS on individual and community health outcomes. Considerations and recommendations for SCS within the context of WDG are also provided, including a local needs assessment with people who use substances.

Discussion

WDGPH and community partners are working together to develop a coordinated and comprehensive approach to reduce opioid-related harms. WDGPH provides local surveillance data, evidence and best practices to inform the development of a community response.

Due to growing concerns about opioid-related deaths and harms across Ontario, there has been increased interest in SCS throughout the province and in WDG, specifically. This report outlines background information and evidence for the impact of SCS on individual and community outcomes from existing research literature. This report also describes current work underway by WDGPH to further explore considerations for SCS within the context of WDG, which highlights some recommended next steps for the community.

Background Information on Supervised Consumption Sites:

SCS is a broad term that refers to the harm reduction practice of providing sterile equipment and a safe and hygienic environment for people to use pre-obtained illicit substances under the supervision of trained service providers, peers or health care professionals without the fear of arrest or accidental fatal overdose. SCS are one component of a wider network of services to meet the needs of people who use drugs and are often seen as a gateway to other services.

- Supervised Injection Sites/Services/Facilities (SIS) and OPS are specific types of SCS. Appendix “A” provides further information comparing features of SCS, SIS, and OPS.
- SIS refer to sites where injection drug use is the only mode of consumption permitted.
- OPS refer to temporary sites that have approval by the MOHLTC to operate.

Until recently, injection drug use was the only mode of consumption permitted in SCS in Canada. Exemptions have been made to allow for intranasal, oral, and inhalation (although there is only one inhalation exemption to date - in Lethbridge, Alberta).[1]

There are five (5) main models for SCS, which vary greatly in terms of size, design and operation.[2] Community characteristics, such as the geographic concentration of drug use and existing community services/programs/infrastructure, influence the appropriateness of each model for the community.[2] Appendix “B” provides information about these different models.

Canadian Context of Supervised Consumption Sites

To operate legally in Canada, SCS require an exemption under section 56.1 of the *Controlled Drugs and Substances Act* by Health Canada. On December 7, 2017, Health Canada issued an exemption to the MOHLTC to establish temporary OPS in order to address the increase in opioid related overdoses. Many communities across Ontario are applying for this low barrier,

time limited exemption.

Demonstrated Impact of Supervised Consumption Sites

SCS engage high-risk and marginalized individuals

It is well established in the literature that SCS tend to engage higher-risk and marginalized individuals. Common demographics of these individuals include:

- injection drug use for many years,
- riskier drug use behaviours, such as a higher frequency of daily drug injection, public injecting, and syringe sharing
- unstable living arrangements or homelessness,
- history of incarceration,
- history of overdose,
- involvement in the sex trade, and
- various health conditions (such as mental health, Hepatitis C, and HIV).[3,4,5,6]

For example, among people who inject drugs in Vancouver, 70% of those who used a SIS reported living in unstable housing, whereas 57% of those who have never used a SIS reported living in unstable housing.[6] The literature suggests that the majority of SCS users are males (roughly between the ages of 30-40 years old). [3,4,5,6]

SCS have shown a positive impact

The literature has found that SCS have a positive impact among individuals who access the services, including a reduction in:

- fatal overdoses on-site,
- drug use behaviours associated with infectious disease (i.e. syringe sharing and syringe reuse), and
- enhanced uptake of health, social services and addictions treatment.[3,7,8] For example, a study among a cohort of Vancouver SIS users (n=1031), demonstrated that the opening of the SIS was associated with a greater than 30% increase in the rate of detoxification service use among SIS users in comparison to the year prior to the SIS opening.[9] Further analysis found that detoxification service use was associated with increased use of methadone and other forms of addiction treatment, as well as reduced injecting at the SIS.

There are additional benefits to the broader community, including a reduction in public injecting and dropped syringes. The evidence does not demonstrate an increase or decrease in local crime, violence, drug-trafficking or local rates of injection use, overall.[3,4,7] The evidence on SCS has demonstrated cost-effectiveness. [3,7,8] For example, a simulation study estimated that Vancouver's Insite prevented 35 new cases of HIV and almost 3 deaths each year, providing a societal benefit of over $6 million, per year, after considering operational costs, which translates to an average benefit-cost ratio of approximately 5:1.[8]

Limitations of SCS research

The majority of research on SCS is specific to SIS. The impact of specific models of SCS have not been teased out in the literature. Vancouver's Insite, which operates as a stand-alone model, is the most heavily researched SCS. OPS, which are often less comprehensive than SCS, have not been evaluated or researched to the same extent. Furthermore, user demographics could potentially vary when other modes of consumption are permitted as part of the service.

The research has largely focused on SCS in large urban centres with an established drug scene. To date, there is a lack of evidence regarding the impact of SCS in smaller communities. However, a newly released feasibility study from London, Ontario (mid-sized city), found that 86% (n=170) of people who inject drugs (PWID) were willing to use a SIS. The local demographics of PWID was consistent with the existing literature.[10] A total of 58% of PWID lived in unstable housing, and of those, 90% reported they would use a SIS.[10]

Many community characteristics can impact the appropriateness of SCS, aside from the intended use among PWID. These additional considerations includes:

- the number and geographic dispersion of PWID in the community,
- drug use behaviours (e.g. drug use in public space versus private residence),
- the number of harms (e.g., overdoses) occurring in the community,
- access to formalized networks of harm reduction social services,
- access to transportation, and
- infrastructure.

Community Data in Wellington-Dufferin-Guelph

Opioid-related harms in WDG

- Between 2003 and 2016, WDG had generally higher rates of opioid-related Emergency Department (ED) visits and opioid-related hospitalizations than the province of Ontario.[11] In general, Guelph and Dufferin appeared to have higher rates of ED visits than the province as a whole, while Wellington appeared to have lower rates.
- In 2017, there were a total of 149 opioid-related ED visits in WDG (data accessed Jan 30, 2018).[12] In 2016, there were a total of 98 opioid-related ED visits in WDG.[13] The increase in opioid-related ED visits could be a result of more people overdosing on opioids, increased attention (i.e. – surveillance/detection bias) resulting from intense media focus and mandated early reporting by the MOHLTC, or a combination of these factors. This data represents the number of visits, rather than unique individuals.
- In 2016, there were a total of 14 opioid-related deaths in WDG (rate of 4.8 per 100,000). In both 2015 and 2014, there was a total of 8 opioid-related deaths each year (rate of 2.8 per 100,000).[11] This data does not indicate the specific location of the deaths (i.e., in a private residence versus a public space). However, Ontario opioid mortality data for May-July 2017, released by the Chief Coroner, has shown that 61.2% of opioid-related deaths occurred in a private residence.[14] It is still unknown how a SCS will impact deaths occurring in private versus public spaces in communities which implement a SCS.

Other relevant local data

In collaboration with community partners, WDGPH provides harm reduction supplies, including the distribution of needles to people who use substances. In 2017, a total of 319,517 needles were distributed to people in WDG – that is, approximately 875 needles a day. Anecdotally, the vast majority are distributed in Guelph.

Unstable living conditions and homelessness was a common demographic characteristics identified in the literature for individuals accessing SCS. The Guelph & Wellington Task Force for Poverty Elimination and the County of Wellington Social Services hosted a Registry Week from April 25th to April 29th, 2016 to survey individuals experiencing homelessness.[15] Of the 295 people identified as experiencing homelessness, 194 (138 adults and 56 youth) completed a more detailed questionnaire, which indicated that individuals experiencing homelessness in Guelph-Wellington are particularly vulnerable. Specifically, the results found that:

- 57% of adults and 66% of youth scored high vulnerability and acuity (meaning high depth of need for permanent supportive housing).
- 23% of adults and 30% of youth reported living with physical health, mental health, and substance use issues, referred to as “tri-morbidity.”
- 31% of adults and 39% of youth reported that drinking or drug use had led them to be kicked out of a place they were staying in the past.
- 17% of adults and 18% of youth reported that drinking or drug use had made it difficult for them to stay housed or afford housing in the future.

Understanding Local Need for Safe Consumption Practices in WDG

While WDGPH is continuously collecting local data to understand local substance use rates and related harms, there is a need to increase our understanding of:

- substance use behaviours in WDG (e.g. substances used, frequency, consumption method, location of use), and
- service and program needs/preferences of people who use substances in WDG.

In order to increase local understanding of these issues, it is critical and a best practice to involve people who use substances in the decision-making. Given this, WDGPH, in collaboration with the Wellington-Guelph Drug Strategy and other community partners, including those with lived experience, are undertaking a needs assessment with people who use illicit substances in Guelph to:

- Increase our understanding of substance use behaviours,
- Identify gaps/needs in services and programs,
- Determine the potential role acceptability, and preferred location of a SCS, and
- Explore the need/suitability for other harm reduction programs and services.

The findings gathered through the community needs assessment will be used to inform local community priorities and actions.

Phase I of the needs assessment will focus on the City of Guelph, as local community agencies and partners are already collaborating on community mobilization efforts to reduce the burden of overdoses. This assessment will inform these community collaborations currently underway to bring a temporary Overdose Prevention Site to the City of Guelph. Phase I will be completed

by May 2018. Phase II will explore interest of community partners to engage local drug users in Wellington and Dufferin County.

Local exploration and planning for OPS (e.g., design and location) through the MOHLTC should be informed by a local needs assessment in addition to careful consultation with relevant community stakeholders (such as the municipal representatives, police, policy makers, community services, local municipal plans, etc.). It should also consider a comprehensive evaluation process to ensure that local needs are being met, and assess the use of community resources and cost-effectiveness moving forward.

Conclusion

WDGPH and community partners are working together to develop a coordinated and comprehensive approach to reduce opioid-related harms. WDGPH will continue to support community partners in providing data, surveillance, evidence, and best practices based on the community picture as it develops.

Needs assessment findings with local drug users will be shared with community partners to inform local priorities and actions moving forward. These data will help to enhance existing, and inform the possible development of new, programs or services to help those who use substances to use safely.

WDGPH is committed to using an evidence-informed approach to improve the health and well-being of people who use substances in WDG.

Ontario Public Health Standard

Foundational Standards:

Healthy Equity

Goal: Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

Effective Public Health Practice

Goal: Public health practice is transparent, responsive to current and emerging evidence, and emphasizes continuous quality improvement.

Population Health Assessment

Goal: Public Health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being with programs and services that are informed by the populations health status, including social determinants of health and health inequities.

Program Standards:

Chronic Disease Prevention and Well-Being

Goal: To reduce the burden of chronic diseases of public health importance and improve well-being.

Substance Use and Injury Prevention

Goal: To reduce the burden of preventable injuries and substance use.

Healthy Environments

Goal: To reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.

Infectious and Communicable Diseases Prevention and Control

Goal: To reduce the burden of communicable diseases and other infectious diseases of public health importance.

WDGPH Strategic Direction(s)

☒ **Health Equity:** We will provide programs and services that integrate health equity principles to reduce or eliminate health differences between population groups.

☐ **Organizational Capacity:** We will improve our capacity to effectively deliver public health programs and services.

☐ **Service Centred Approach:** We are committed to providing excellent service to anyone interacting with WDG Public Health.

☒ **Building Healthy Communities:** We will work with communities to support the health and well-being of everyone.

Health Equity

Health equity principles are being applied across all WDGPH opioid projects with the goal of reducing or eliminating differences in opioid-related harms between population groups. It has been consistently demonstrated in the literature that SCS engage higher-risk and marginalized individuals, including those with: (i) unstable living arrangements or homelessness; (ii) a history of incarceration; (iii) a history of overdose; (iv) a history of long-term injection drug use; (v) involvement in the sex trade; and (vi) various health conditions (such as mental health, Hepatitis C, and HIV).[3,4,5,6]

Community engagement is a key approach to improving health equity through action on the social determinants of health.[16] The needs assessment currently underway will meaningfully engage and incorporate the voices of people who are using substances in the community to address their needs and improve health outcomes.

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Appendices

Appendix "A" - At a glance comparison of Supervised Consumption Services and more specifically Supervised Injection Services and Overdose Prevention Sites in Ontario.

Appendix "B" - At a glance comparison of five (5) different models for SCS.

APPENDIX "A"

At a glance comparison of Supervised Consumption Services, and more specifically Supervised Injection Services and Overdose Prevention Sites in Ontario

	Supervised Consumption Sites/Services (General)	Supervised Injection Sites/Services	Overdose Prevention Sites
Consumption methods allowed	Injection Intranasal Oral +/- Inhalation (currently none in Ontario)	Injection	Injection Intranasal Oral
Model: **- Stand-alone (S)** **- Integrated (I)** **- Embedded (E)** **- Mobile (M)**	S, I, E, M	S, I, E, M	S, I, E, M
Comprehensive (e.g. on-site health care, counselling, referrals to primary care, treatment, housing, social services)	Very	Very	Less
Application process	More onerous Federal	More onerous Federal	Less onerous Provincial
Permanent	Yes*	Yes*	No (3-6 months with possibility of extension)
Operational Requirements	-Medical staff required on-site. -Only licensed medical and health care professionals authorized to supervise.** -Peer-to-peer assisted injection is not allowed.	-Medical staff required on-site. -Only licensed medical and health care professionals authorized to supervise.** -Peer-to-peer assisted injection is not allowed.	-Medical staff not required on-site (but need to be available). -Non-medical staff (including peers) are authorized to supervise (need CPR and naloxone training). -Peer-to-peer assisted injection is allowed.

***Approval is still subject to an expiry date.**

**** Federal government is in the process of reviewing the Act's restrictions[2]**

APPENDIX "B"

At a glance comparison of five (5) different models for SCS

Model	Description	Recommended Setting	Advantages	Example
Stand-alone	This is a distinct facility with a primary goal of providing SCS. Although other services, such as showers, meals, temporary housing, counselling, etc., may be provided as well, the majority of the facilities resources are dedicated towards the SCS program.	Appropriate in settings with large concentrations of people who inject drugs (PWID), including settings with established drug scenes.	May better reach clients who actively avoid health care services. Facility's services can be catered to PWID.	Insite, Vancouver
Integrated	This SCS is one of many different services offered inside a larger facility, typically acting as a "one-stop-shop" for harm reduction and health care services for people who may face complex health and social challenges. This is the most common type of SCS.	Appropriate in settings where PWID tend to be dispersed. (Other services attract people to facility as well).	Promotes uptake (and reduces barriers) of other services offered in same facility.	Sandy Hill Community Health Centre, Ottawa
Embedded	This SCS is embedded in other settings (such as hospitals, shelters, etc.) that traditionally do not allow drug use, but where drug use still occurs onsite.	Appropriate in program settings that are frequented by PWID and where drug use occurs on-site.	Well-suited settings because they are frequented by PWID.	Lariboisière Hospital, Paris, France
Mobile-Outreach	This SCS consists of a modified van or bus that can be moved to locations where public drug use occurs and where current services are out of reach for PWID.	Local drug scene is not centralized, but rather dispersed across a large geographical area. (Usually compliments fixed SCS).	May be more socially acceptable for local stakeholders than a fixed-site.	Mobile site, Montreal
Women-Only	SCS are provided in a protected space to addresses the unique barriers, challenges and dangers that women experience (e.g. physical and sexual violence).	Appropriate where there are sufficient populations of women who inject drugs.	Women report less hassling, and feel more comfortable, and safe.[2]	Women-Only site, Hamburg, Germany

Information adapted from: British Columbia Centre on Substance Abuse. Supervised Consumption Services. Operational Guidance. 2017.