



## Commentary

## Applying the lessons of COVID-19 response to Canada's worsening opioid epidemic

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Global pandemics, such as coronavirus disease 2019 (COVID-19), often reveal glaring deficiencies within our public health systems. However, such major public health threats also present opportunities to strengthen existing public health structures and responses. Past communicable disease pandemics, such as severe acute respiratory syndrome (SARS) in 2003 and H1N1 influenza in 2009, exposed systemic weaknesses in the ability of global health systems to respond to novel pathogens, but led to new protocols and improved infrastructure [1,2]. The current COVID-19 pandemic, while associated with significant morbidity and mortality, has created yet another opportunity for reflection: specifically, on the equity of pandemic response. The current situation in Canada, where the co-occurring epidemics of COVID-19 and opioid-related overdose persist, presents a useful case example of such inequities.

The Canadian COVID-19 response has been lauded at home and internationally for its early success in flattening the COVID-19 “curve.” At the same time, the opioid response is receiving increasing criticism from public health experts [3]. In the province of British Columbia (BC), the epicentre of the opioid epidemic and where an opioid overdose public health emergency was declared in 2016, more than 5800 lives have been claimed, largely due to the presence of fentanyl and other synthetic opioid analogues in the illicit drug supply, which are highly potent and can easily lead to overdose [4]. In March 2020, COVID-19 became BC’s second-ever public health emergency (after the opioid overdose public health emergency), resulting in a number of measures that exacerbated the opioid epidemic. For example, the Canadian–US border closure disrupted drug supply chains, increasing drug toxicity and extreme fentanyl concentrations [4]. Social distancing and self-isolation measures, in combination with reduced access to services such as supervised consumption facilities, health care and other harm reduction services, have increased the

risk of withdrawal, treatment interruptions, overdose, and mortality [5].

In June, BC recorded its worst number of opioid-related deaths ever: 183, up from 76 in June of 2019 [4]. On June 26, 2020, paramedics in the province responded to 131 overdose calls, the highest recorded in a single day [6]. Many people have died alone in their own homes, isolated in part because of social distancing measures. The number of opioid-related deaths this summer alone has far exceeded the total of 284 deaths in BC due to COVID-19 [7].

Canada has a long history of responding to pandemics. In 1918, the arrival of the Spanish Flu was met with confusion over authority, jurisdiction, and information sharing, resulting in an ad hoc response but contributing in large part to the creation of the Department of Health. With the SARS outbreak in 2003, Canada was again challenged with a lack of coordination across institutions and jurisdictions, as well as systemic deficiencies in clinical and health care settings, epidemiologic investigation, and outbreak management and emergency protocols. The SARS outbreak, and the recommendations that stemmed from it, helped inform the structure of the current public health system, including the creation of the Public Health Agency of Canada, now leading the COVID-19 response.

The current COVID-19 and opioid-related overdose public health crises afflicting Canada and BC have revealed two things: that Canada has learned from past pandemics and created robust public health infrastructure in response, and that the full force of Canadian public health intervention is not equitably deployed. What COVID-19 has demonstrated is that science, policy, and data can be rapidly mobilized. On March 23, 2020, 12 days after the World Health Organization declared COVID-19 a global pandemic, the federal government announced \$275 million in funding for coronavirus research and medical countermeasures [8]. Seventy-one clinical trials for drugs and vaccines have since been authorized [9]. Epidemiological data is released daily.

Canada has not witnessed the same action on the opioid crisis. Up-to-date epidemiological data at the national level is not available. Harm reduction—an approach that reduces the harms associated with substance use—remains under ideological assail, even during COVID-19. For example, in August 2020, in the province of Alberta, the United Conservative Party-led government closed North America’s busiest safe consumption site (SCS) in the face of significant research and evidence demonstrating that SCSs save lives and reduce drug-related harms, opting to instead focus on abstinence-based approaches [10]. Government investments in research and clinical

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trials for opioid use disorder remain limited. Two policy interventions that would have an immediate impact and save lives, but have not been broadly implemented, are the decriminalization of personal use of drugs and the provision of a “safe supply” of legal and regulated pharmaceutical-grade drugs.<sup>3</sup> These policy interventions are supported by high-ranking health officials, including BC’s Provincial Health Officer and Chief Coroner, but continue to face legal and regulatory barriers that prevent them from being widely available. A more significant barrier has been politicians and decision-makers, who are reticent to implement these policies despite mounting death tolls.

COVID-19 has highlighted the Canadian public health system’s strengths. It has also created opportunities for learning. Officials are realizing that pandemic response can have unintended consequences of immense scale. With every passing month, it becomes clearer that the full force of Canadian public health intervention is not equitably deployed. The time has come to set the balance right and leverage learnings from the present and past pandemics to adequately respond to the opioid overdose epidemic.

### Declaration of Competing Interest

The authors have nothing to disclose.

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