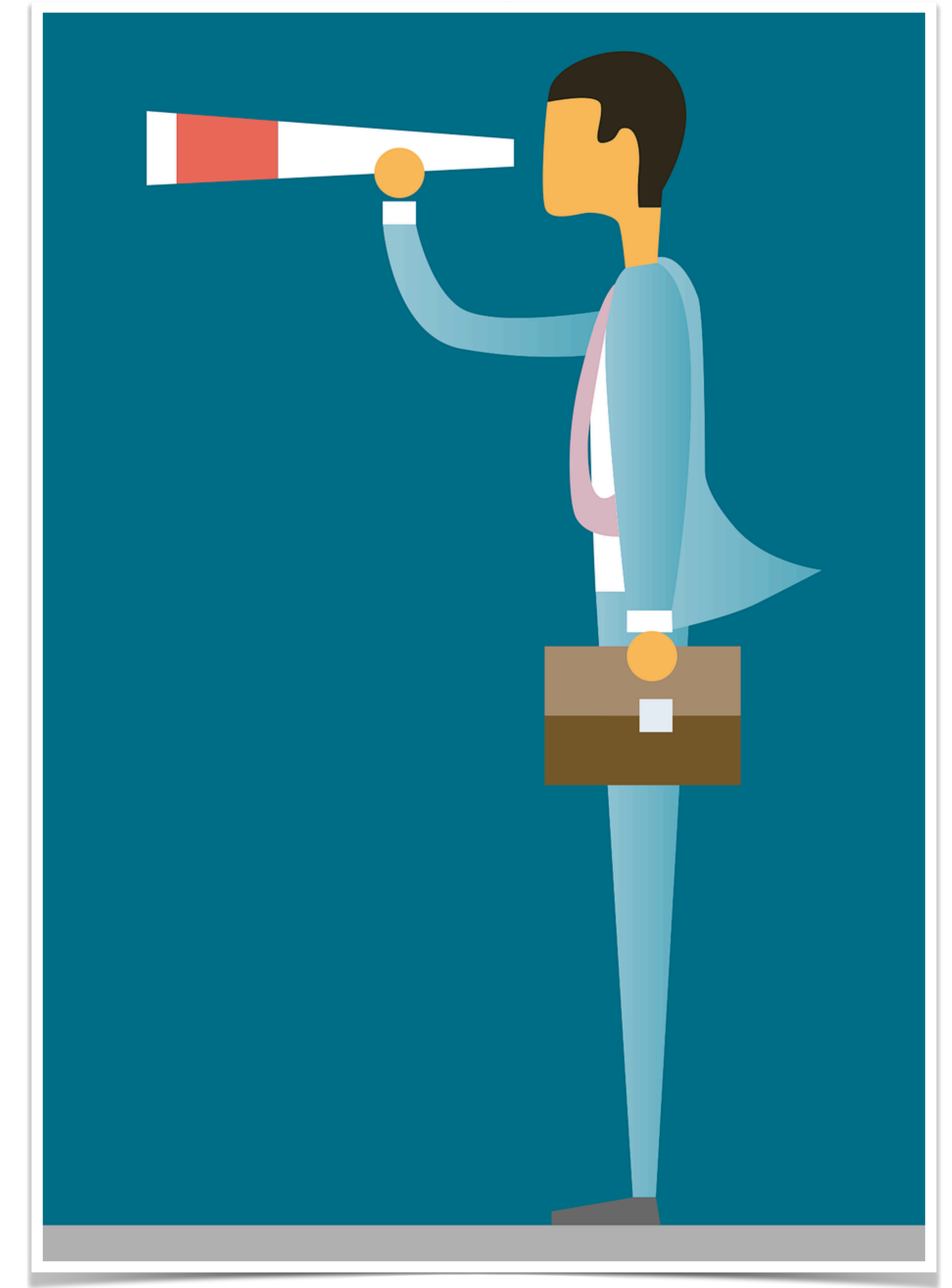
Safe Drug Supply

Presentation to the Harm Reduction & Critical Drug Studies REG

Pablo Navarro, February 17, in this, the third year of our pandemic.

Presentation Overview

- Background
- Evidence for effectiveness
- Contextualization
- Questions and discussion



Background

Terms and Definitions

- Safe Drug Supply:

  "a legal and regulated supply of drugs with mind/body altering properties that traditionally have been accessible only through the illicit drug market"

https://vancouver.ca/files/cov/capud-safe-supply-concept-document.pdf
https://time.com/6108812/drug-deaths-safe-supply-opioids/
https://filtermag.org/vancouver-free-drugs-safe-supply/

Background

Terms and Definitions

- Includes opioids such as heroin, stimulants such as cocaine and crystal methamphetamine, hallucinogens such as MDMA and LSD, and marijuana.
- Includes injectable drugs.
- Does not include substitution treatments, e.g., methadone or suboxone.

https://www.canada.ca/en/health-canada/services/opioids/responding-canada-opioid-crisis/safer-supply.html
https://vancouver.ca/files/cov/capud-safe-supply-concept-document.pdf
https://www.dulf.ca/

Background

History and Antecedents

- Dr. John Marks, Liverpool, 1982-1995
  - Familiar opioid epidemic conditions
  - In midst of nascent, global harm reduction movement (HIV, IDU)
  - Building on “maintenance prescribing” and develops into Heroin Assisted Treatment (Switzerland, Netherlands, Germany, Australia, Canada)

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Contents lists available at ScienceDirect

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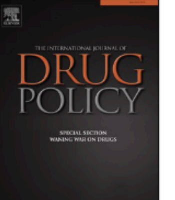

Policy Analysis

Prescribing heroin: John Marks, the Merseyside clinics, and lessons from history

Toby Seddon

School of Law, University of Manchester, Oxford Road, Manchester M13 9PL, UK

ARTICLE INFO

Keywords:
Heroin
Heroin maintenance
John Marks
Treatment
Rolleston
risk

ABSTRACT

The prescribing of heroin has a long and contentious history as a method for treating people with heroin problems. This paper revisits a controversial ‘experiment’ with heroin prescribing in Northwest England between 1982 and 1995, led by the psychiatrist Dr. John Marks. Marks’ work has been shrouded in myth and misinformation for many years and the paper presents an evidence-based reconstruction of this episode, drawing on archival sources, published and unpublished documents, and a small number of interviews with key informants. During this 13-year period, Marks worked across clinics in Liverpool and two neighbouring towns, founding his practice on the long-term maintenance prescribing of opiates, including injectable heroin and smokable heroin reefers. The high media profile of the work, in the context of a febrile local politics in Liverpool, a powerful British addiction psychiatry establishment and an always-heated international politics of drug control, brought immense political pressure and led eventually to the closure of the clinics. The Marks ‘experiment’ raises important challenges to the premises, practices and philosophy of heroin maintenance – particularly the questions of thresholds and criteria for access, and the purposes of intervention – as well as to the wider regime of prohibitive drug laws.

Introduction

In the early 1980s, the proud English city of Liverpool was struggling. The riots in the inner-city area of Toxteth in the summer of 1981 signalled a city in distress, scarred by mass unemployment, poor housing, and the beginnings of what would become an unprecedented ‘epidemic’ of youth heroin use (Roberts, 1989). In the very poorest neighbourhoods and housing estates, the constellation of drugs, crime and deprivation formed a pattern of entrenched multiple disadvantage (Seddon, 2006). Once one of the greatest maritime cities in the world, by the mid-1980s Liverpool was in ruinous decline, exemplified by its new media moniker as ‘smack city’ (see Sykes, Brown & Cocks, 2013).

This toxic mix of social and economic problems threatened to overwhelm the city. A confidential government document at the time proposed a policy of ‘managed decline’, rather than wasting limited resources on regeneration efforts that were considered unlikely to succeed.[1] A divisive local council politics, driven by the far-left Militant group (see Crick, 2016), seemed to be pushing the city even closer to the brink. Yet some more positive developments were also emerging. The roots of what would become the global harm reduction movement took hold in Liverpool at this time, with pioneering approaches to drugs and HIV problems being developed, including the first syringe exchange schemes (Ashton & Seymour, 2010). In the middle of this maelstrom was consultant psychiatrist Dr. John Marks, at the sharp end of drug problems running the city-centre Drug Dependency Clinic in Hope Street. His radical approach to heroin prescribing would become a focus for international debate on drug policy. Lauded by supporters as a humane doctor responding pragmatically to an extraordinary social problem, his critics denounced him as an irresponsible maverick who risked prolonging addiction careers and expanding the heroin-using population.

Over the years, a degree of mythology and misinformation has grown up around Marks’ work and the purpose of this paper is to set out an evidence-based account of events. It focuses on Marks’ heroin prescribing practice in Merseyside during the period from 1982 to 1995, drawing on published and unpublished documents, archival sources,

E-mail address: toby.seddon@manchester.ac.uk.

[1] This position was set out in a confidential letter on 4th September 1981 from Chancellor of the Exchequer Geoffrey Howe to Prime Minister Margaret Thatcher. Howe described tackling the problems on Merseyside as potentially like ‘trying to make water flow uphill’.

https://doi.org/10.1016/j.drugpo.2020.102730

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https://transformdrugs.org/drug-policy/uk-drug-policy/heroin-assisted-treatment
https://doi.org/10.1016/j.drugpo.2020.102730
https://www.youtube.com/watch?v=Zy_86iVhmkQ

Background

History and Antecedents

- Dr. John Marks, Liverpool, 1982-1995
  - Oral methadone attempted first
  - Pragmatic approach (individual health, community health, social benefits)
  - Claimed decreased rates of overdose, HIV transmission
  - Political hot potato (local, professional, international)

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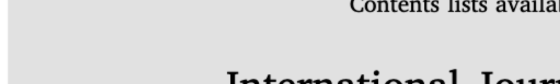

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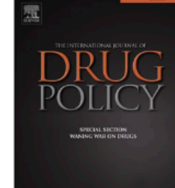

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Background

Concerns and counter-arguments

- Physician creed "first do no harm", side-effects, e.g., endocarditis
- Local economic effects and health impacts
- Alternatives: iOAT (hydromorphone)
- Motivated by desperation / alarm, not addressing underlying/core issues
- Lack of evidence?

OPINION

As a doctor, I was taught 'first do no harm.' That's why I have concerns with the so-called 'safe supply' of drugs

Overprescribing opioids got us into a deadly mess, and we've convinced ourselves that prescribing more will get us out of it. We need better solutions before more users are hurt

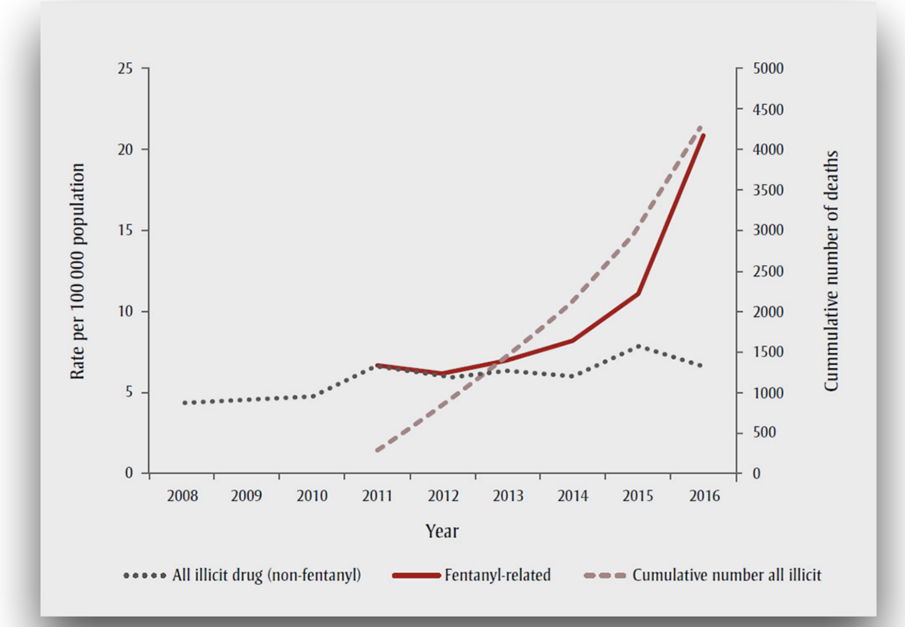
VINCENT LAM
SPECIAL TO THE GLOBE AND MAIL
PUBLISHED NOVEMBER 20, 2021
UPDATED NOVEMBER 22, 2021

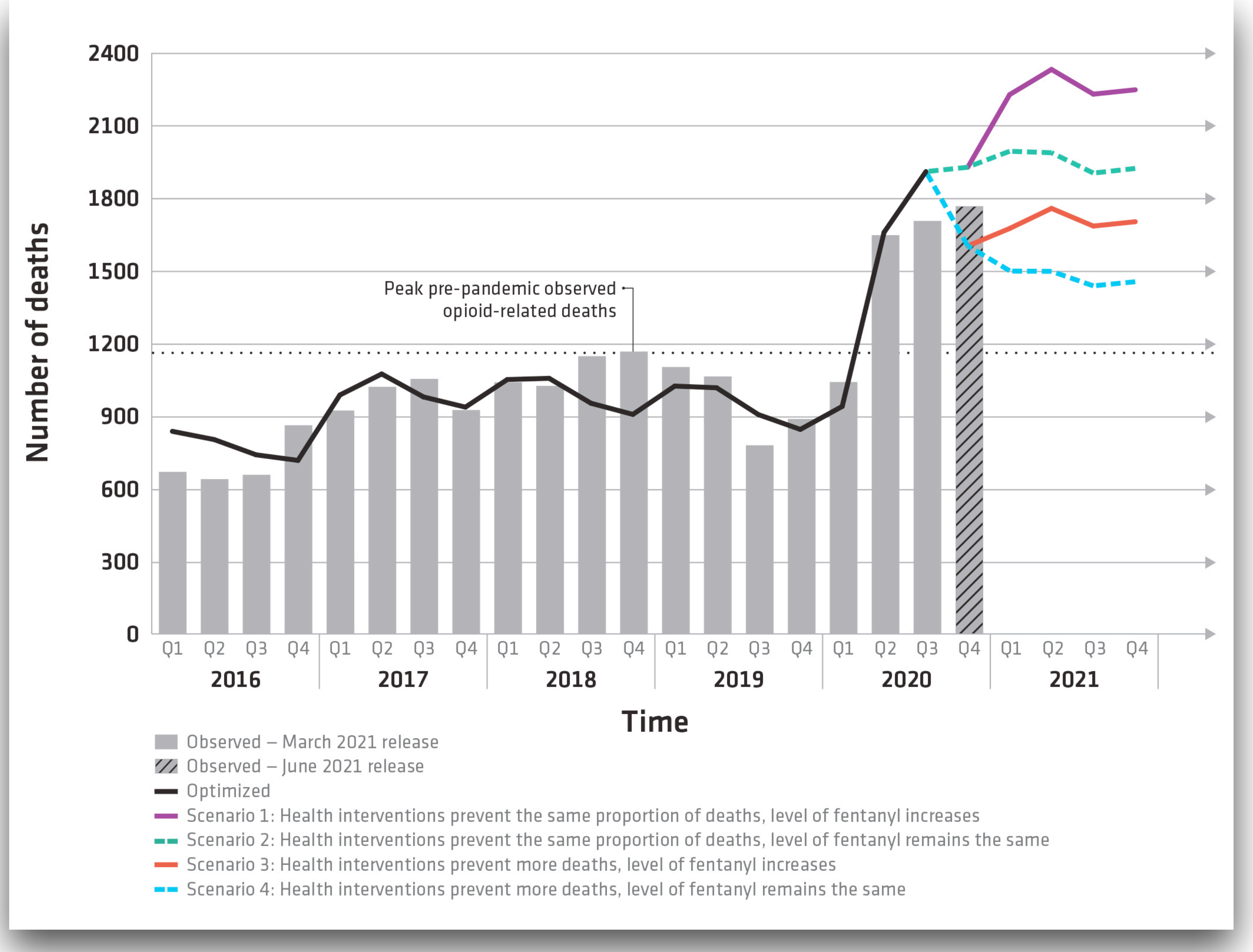
https://www.theglobeandmail.com/opinion/article-as-a-doctor-i-was-taught-first-do-no-harm-thats-why-i-have-a-problem/

https://healthydebate.ca/2019/08/topic/safe-supply/

Background

Need for Action





Number and rates (per 100,000 population) of total **apparent opioid toxicity deaths by province and territory in** 2021 (Jan to Jun)

Canada 3,515

Rate per 100,000 population
20.0 and higher
15.0 to 19.9
10.0 to 14.9
5.0 to 9.9
0.0 to 4.9
Suppressed
Not available

10, 2, suppr., 1,028, 708, 96, n/a, 1,414, 212, 5, 3, 23, 14

Number of deaths

Includes deaths related to all illicit drugs including, but not limited to, opioids

2020 data from Manitoba are based on January to March.
2021 data from Newfoundland and Labrador are based on January to March.

Canada

Crude rate (per 100,000 population)
2016, 2017, 2018, 2019, 2020, 2021 (Jan to J
Year

Number
Q1 Q3 Q1 Q3 Q1 Q3 Q1 Q3 Q1 Q3 Q1
2016, 2017, 2018, 2019, 2020, 2021
Year and quarter

Download data

https://www.canada.ca/en/public-health/services/reports-publications/health-promotion-chronic-disease-prevention-canada-research-policy-practice/vol-38-no-6-2018/evidence-synthesis-opioid-crisis-canada-national-perspective.html
https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/
https://angusreid.org/opioid-crisis-covid/
https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC6034966/
https://www150.statcan.gc.ca/n1/pub/82-003-x/82-003-x2021002-eng.htm

Evidence

“Effectiveness”

- Many kinds of effectiveness: individual (health status, behaviour), community (family, ACEs), health system (access to services, recruitment), societal (costs, crime), etc.
- Implementation effects very significant: dispensing models, approach to conflict, ethical framework

Emerging evidence & outcomes of safer supply approaches

In Ontario, several SOS models currently exist with an increasing number of prescribers that are engaging in this approach. Often SOS programs are located within Community Health Centres, where in addition to primary care, clients can also be connected to a broad range of psychosocial supports. While evidence in support of SOS is emerging, preliminary findings show:

- Increased engagement with healthcare service providers
- A reduction in illicit and intravenous drug use
- Decrease in opioid overdoses rates
- Decreases in the number of people experiencing homelessness
- Reduced engagement with survival sex work
- A decrease in money spent on street drugs

How is it helping improve the lives of PWUD?

There’s a standard of drugs that you know what you’re getting when you get this. Here, if you get it on the corner, you don’t know what you’re getting. You might think you do, but you don’t.

Nobody has to steal anymore. Nobody has to do that. You can… satisfy your needs and do what you need to do without having to do anything illegal. I don’t have to steal. I don’t have to sell dope.

https://ontario.cmha.ca/wp-content/uploads/2021/02/SaferSupplyInfographic-EN-FINAL.pdf

Evidence

Support for Rationale

- Significant number of PWUDs unwilling to give up high
- Substitution drugs (e.g., methadone) not successful with significant numbers of PWUDs
- Significant number of PWUDs not seeking treatment options
- Relapse rates remain high

Kerr T. Public health responses to the opioid crisis in North America. Journal of Epidemiology and Community Health. 2019;73(5):377–378.
Rai, N. Sereda, A. Hales, J. Kolla, G. Urgent call on clinicians: Prescribe alternatives to poisoned drug supply. 2019. https://healthydebate.ca/opinions/saf-er-supply-opioids.
Smith, C. Doctor suggests giving opioid users legal drugs. 2020. https://www.cbc.ca/news/canada/new-brunswick/street-drugs-addiction-fentanyl-opioids-safe-supply-1.5489092.

Evidence

North American Opiate Medication Initiative - NAOMI Study

- More effective retention
- Reduced use of illicit drugs, i.e., potential exposure to fentanyl
- “The diacetylmorphine group had greater improvements with respect to medical and psychiatric status, economic status, employment situation, and family and social relations.”

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Diacetylmorphine versus Methadone for the Treatment of Opioid Addiction

Eugenia Oviedo-Joekes, Ph.D., Suzanne Brissette, M.D., David C. Marsh, M.D., Pierre Lauzon, M.D., Daphne Guh, M.Sc., Aslam Anis, Ph.D., and Martin T. Schechter, M.D., Ph.D.

ABSTRACT

BACKGROUND

Studies in Europe have suggested that injectable diacetylmorphine, the active ingredient in heroin, can be an effective adjunctive treatment for chronic, relapsing opioid dependence.

METHODS

In an open-label, phase 3, randomized, controlled trial in Canada, we compared injectable diacetylmorphine with oral methadone maintenance therapy in patients with opioid dependence that was refractory to treatment. Long-term users of injectable heroin who had not benefited from at least two previous attempts at treatment for addiction (including at least one methadone treatment) were randomly assigned to receive methadone (111 patients) or diacetylmorphine (115 patients). The primary outcomes, assessed at 12 months, were retention in addiction treatment or drug-free status and a reduction in illicit-drug use or other illegal activity according to the European Addiction Severity Index.

RESULTS

The primary outcomes were determined in 95.2% of the participants. On the basis of an intention-to-treat analysis, the rate of retention in addiction treatment in the diacetylmorphine group was 87.8%, as compared with 54.1% in the methadone group (rate ratio for retention, 1.62; 95% confidence interval [CI], 1.35 to 1.95; P<0.001). The reduction in rates of illicit-drug use or other illegal activity was 67.0% in the diacetylmorphine group and 47.7% in the methadone group (rate ratio, 1.40; 95% CI, 1.11 to 1.77; P=0.004). The most common serious adverse events associated with diacetylmorphine injections were overdoses (in 10 patients) and seizures (in 6 patients).

CONCLUSIONS

Injectable diacetylmorphine was more effective than oral methadone. Because of a risk of overdoses and seizures, diacetylmorphine maintenance therapy should be delivered in settings where prompt medical intervention is available. (ClinicalTrials.gov number, NCT00175357.)

From the School of Population and Public Health, University of British Columbia (E.O.-J., D.C.M., A.A., M.T.S.); the Centre for Health Evaluation and Outcome Sciences, Providence Health Care (E.O.-J., D.C.M., D.G., A.A., M.T.S.); and Vancouver Coastal Health (D.C.M.) — all in Vancouver, BC, Canada; and the Centre de Recherche de l'Université de Montréal (S.B., P.L.) and the Centre de Recherche et Aide aux Narcomanes (P.L.) — both in Montreal. Address reprint requests to Dr. Schechter at the University of British Columbia School of Population and Public Health, 5804 Fairview Ave., Vancouver, BC V6T 1Z3, Canada, or at martin.schechter@ubc.ca.

N Engl J Med 2009;361:777-86.
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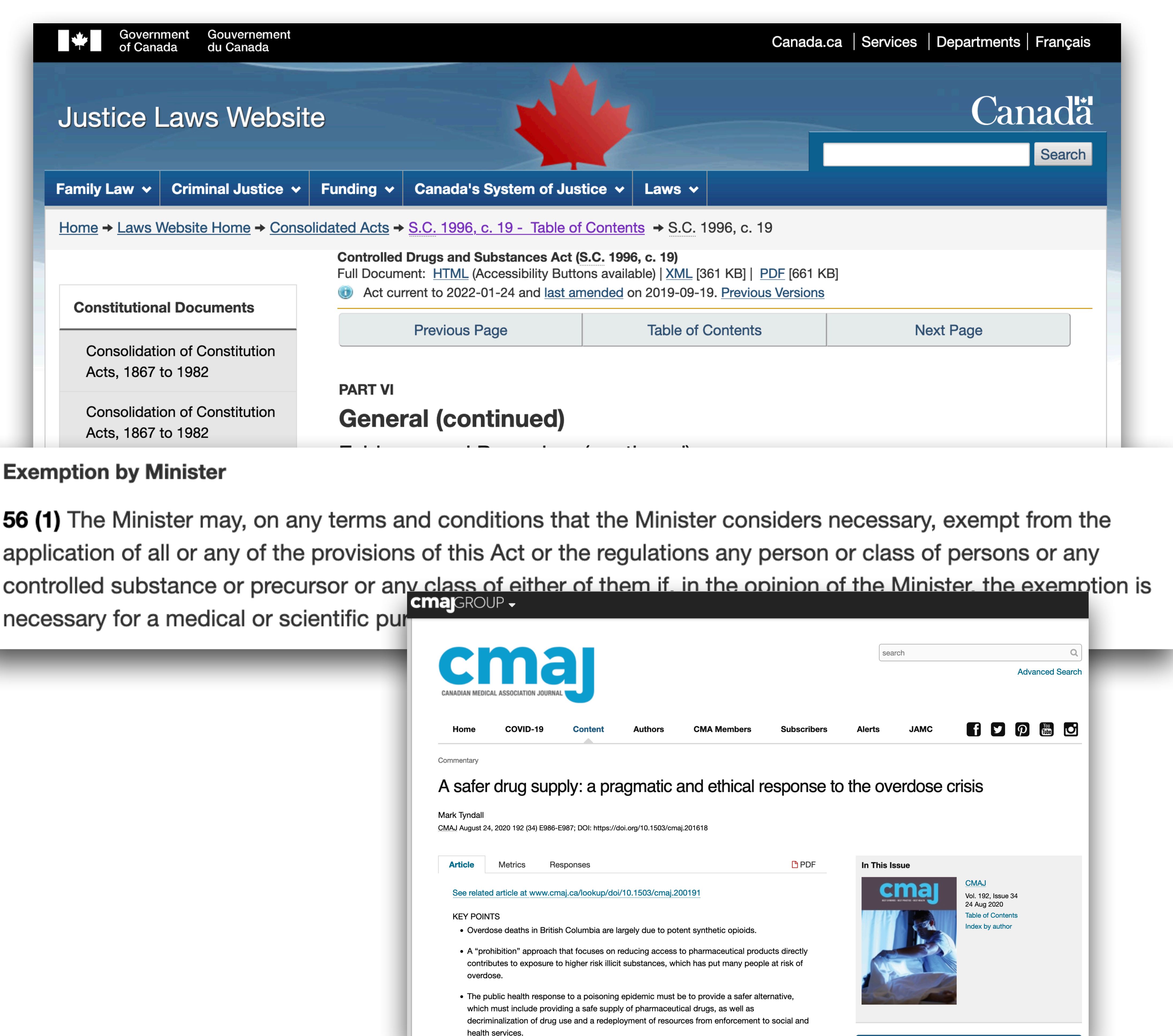
https://www.nejm.org/doi/full/10.1056/NEJMoa0810635

Contextualization

Additional Considerations

- Safe drug supply and harm reduction in a criminalized drug use context
- Framing as a poisoning epidemic
- Safe Drug Supply within scope of practice for physicians, pharmacists
- Potential for legal exemptions for designated groups (CDSA 56(1))
- Supervised use vs. “carries”



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https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7252037/pdf/main.pdf

Thank you for your time

pnavarro@mun.ca