Ending the overdose epidemic by ending the war on drug users: Can this work?

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The overdose crisis continues to escalate. In Canada and the United States, more than 120 000 people now die annually, twice the toll in 2015.[1,2] In the global epicentre, the Canadian province of British Columbia, this corresponds to 7–8 deaths each day.

The first wave of increased mortality was prompted by excessive and poorly overseen opioid prescribing. The more recent escalations reflect changing street drug markets, including the sale of, and growing appetite for, extremely potent, cheap-to-produce synthetic opioids, benzodiazepines, and amphetamines.[3–5] Since most policy experts agree that criminalizing these activities has failed to help,[6–9] some have proposed a decriminalization-based approach. The effectiveness of this strategy depends on how well it is executed. Some of the challenges are illustrated in the following composite cases.

Vignette 1

For much of her early childhood, "Julie" was sexually abused by her father. At age 15, he sold her into slavery where she was trafficked around the world and forced to have sex with several men each day. In her early 20s, she escaped and found a supportive community. Both antidepressants and trauma therapy were provided. Both were helpful. And yet, the horrors of her past did not disappear. Instead, Julie found that the best way to achieve some peace and not kill herself was by using opioids. Methadone and buprenorphine were, for her, unpleasant, but a combination of heroin, psychotherapy, and antidepressants allowed her to get through the day and experience some happiness. When heroin was easily available, she reported, she could maintain a job and life that felt constructive, productive, and protected from the worst emotional pain.

Vignette 2

"Bob" didn't drink. His father had struggled with anger and alcohol for most of his life, and Bob was determined to live his life differently. Following a work-related accident, he was prescribed a new painkiller, highly effective, he was told, and nonaddictive. It worked well and he was told not to worry about the need for progressively higher doses. Six years later, he was informed that new guidelines required dose reductions, leading to prescription termination. Bob tried, but the discomfort was too great. When an acquaintance offered him some fentanyl, he jumped at the chance. Two weeks later, he experienced a severe overdose.

Issues to address

What types of policies will best help patients like Julie and Bob? The following questions outline issues to be addressed.

Should Julie be arrested for heroin possession? The weight of evidence suggests that this would accomplish little.[6–9] Incarceration could traumatize her further, increase the risk of a fatal overdose,[15,16] and produce minimal to no deterrent effects on others.[8]

Is an abstinence-oriented treatment regimen an appropriate option? This is complex. Emotional pain can be analogous to physical pain. Opioids can soothe both.[17,18] Since existing therapies do not fully erase the damage done by earlier traumas, some people might well conclude that opioids offer the most realistic chance for periodic peace. This can be challenging to contemplate for illegal drugs, but prohibitionist policies bring us back to the point in the above paragraph. More effective is a collaborative approach that embraces different goals at different times. Abstinence can be one of these goals but the overarching objective is to help the individual deal with the trauma while reducing the risk of overdose and death.

Should Bob have been prescribed lower doses? Dose tapering might be helpful for some patients,[19] but can also lead to increased use of illicit opioids, increased overdoses, and increased mental health crises.[20,21]

Should Bob have been prescribed higher doses? This is an option, although opioids should not be considered a first-line choice for chronic pain. Moreover, given his family background,

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any opioid prescription would need to be accompanied by close monitoring with frequent follow-up assessments. Non-opioid treatments should be considered, including cognitive, behavioural, and occupational therapies to address both his physical pain and early life history. Indeed, given his motivation to avoid an addiction, Bob would be a good candidate for these non-pharmacological therapies.

Vignette 1, continued

In early 2023, Julie learned that she could now carry a few days' supply of heroin (2.5 g) without fear of arrest. Combined with a recently acquired prescription for pharmaceutical-grade heroin, a major source of stress was reduced. The number of participating pharmacies was low, but a nearby vending machine dispensed the same drugs, conveniently providing a reliable source of known strength. These pills were not always taken as prescribed. Some were stockpiled to protect against future shortages, others were sold for income. The latter strategy became particularly important when the restaurant she worked at closed and she was unable to find another job. When her boyfriend encouraged her to make additional money from sex work, this felt necessary too, but it triggered traumatic memories and created new ones, and a negative emotional spiral began.

Vignette 2, continued

Bob's overdose occurred while with a friend. Fortunately, both carried naloxone kits and knew how to use them. The high potency of fentanyl required the friend to administer 2 doses, but Bob survived. Later that day, now wracked with pain but determined to find another solution, he sought help at an addictions clinic. The staff were friendly, but there was a 2-month waiting list. He did not survive the delay.

How can we address the overdose epidemic?

There is no single measure that will resolve the crisis, but a multi-component approach has promise.[22–26] Core features need to include:

Prevention: early interventions for youth at risk targeting mood and impulse control and protection from abuse; access to quality education, jobs, housing, and health care, tailored to the needs of diverse communities; judicious analgesic prescribing practices that consider alternative options without denying opioids to those in need; and online overdose prevention.

Treatment: rapid access to long-term psychosocial support, therapy, and peer-mentoring; withdrawal management for those who are ready, and prescription substances for those who are not; and treatment of other mental and physical health problems, with family engagement.

Harm reduction: free and prescription-free access to needle exchange and naloxone; supervised consumption sites; and safe supply programs in a therapeutic context.

Enforcement: protection from violence, alongside decriminalized possession of small quantities of drugs for personal use.

This 4-pronged approach is nominally part of Canada's drug strategy, but implementation has been only partial. Countries that have implemented the strategy more fully (parts of Europe and Australia) have seen reductions in costs related to high-risk substance use, both social and economic.[24–26] The importance of implementing this strategy well is underscored by recent developments in Portugal, the site of a much-lauded decriminalization program initiated in 2001. Over the last decade, program funding has decreased, and this has been followed by increased opioid use and mortality.[27,28]

Influenced by this evidence, British Columbia recently proposed implementation in full as a 3-year trial.[29] As of Jan. 31, 2023, decriminalization for small quantities of opioids, cocaine, methamphetamine, and 3,4-methylenedioxy-methamphetamine (MDMA) is to be accompanied by increased access to health and social services; increased investments in social housing, education and job creation; and greater engagement with the most severely affected communities, such as Indigenous Peoples (Box 1). Outside of British Columbia, and Canada-wide since 2020, police services have been encouraged to deprioritize arrests for simple possession except for the most severe cases.

It is too early to evaluate these programs' efficacy, but some features can be commented on. On the plus side, there has been a concerted effort in BC to increase affordable housing,[30] safe supply programs,[25] employment[31] and education opportunities,[32,33] access to treatment for addictions and other medical problems,[34] and streamlined addiction care services that decrease both waiting times and the dangerous gap between detox treatment and follow-up support.[35] On the downside, there is little evidence of substantial new investments in job creation outside of the government sector.[31] The safe supply programs decrease the hazard of variable drug strength,[36] but there is simultaneously too little access — diminishing the number of people who can benefit[37] — and, in some cases, too little clinical oversight (e.g., biometric drug dispensing machines[38]), increasing the risk of diversion.[25,39] If the diverted supply goes to other people with addictions, this need not be a bad outcome. Some diversions, though, might lead to new addictions and other harms.[40] Elsewhere in Canada, rapid access treatment programs have shown efficacy[41] but these services are offered to too few people.[42] Finally, concern has been expressed that policies are being introduced without adequate consideration

Box 1: Demographic features

In Canada and the United States, sex, gender, ethnic, and racial differences in the prevalence of substance use disorders (SUDs) are evident, yet these effects are both smaller and different from what is commonly depicted.[10–12] For example, lifetime SUD rates are not higher in Black than White communities. Much larger effects are seen with regard to family income, especially on past-year SUDs.[11] This latter effect is thought to reflect, in large part, disparities in access to treatment and other resources.

A different pattern of effects has been seen for overdose deaths.[13,14] For the past 3 decades in the US, these deaths have predominantly affected White communities, with Black communities now starting to be affected more. In Canada, and in British Columbia especially, rates of overdose deaths have been highest among Indigenous communities, followed by those of White European ancestry.[14]

of the details. For instance, are regionally specific features being considered? Is the 2.5-g limit too low for people who need to buy in bulk for economic or geographic reasons (e.g., living far from sellers)? Are the new housing developments destroying existing low-income housing?[30,31,39,43,44] Indeed, BC's chief coroner recently resigned, expressing frustration about a response described as incremental and poorly integrated.[45]

Conclusion

Deaths from drug overdoses have reached previously unimaginable levels. Criminalization aggravated the situation, marginalizing and stigmatizing users with mental health problems who were often in desperate need of care. The BC strategy aims to address these issues and has much potential. It will accomplish little, though — and could make things worse — unless the programs are adequately funded, carefully monitored, and adjusted when needed. Clinicians and researchers have an important role to play by learning, advising, implementing, and critiquing, pursuing more effective treatments within an integrated system of care.

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