Public health and the fentanyl crisis in B.C.: An interview with Dr. Jane Buxton

Sympascho Young[1]
Citation: UBCMJ. 2018: 10.1 (31-32)

Introduction

A public health emergency was declared in B.C. on April 14, 2016 in response to the rise in opioid overdoses and deaths.[1] More than a year later, the opioid epidemic is still surging and has spread from the epicenter of the Downtown Eastside to touch every part of the province of B.C. Dr. Jane Buxton is the Harm Reductions medical lead at the B.C. Centre for Disease Control (BCCDC) and a professor at the UBC Faculty of Medicine and School of Population and Public Health. Dr. Buxton founded the provincial Take Home Naloxone (BCTHN) program in 2012. Under her leadership, the program has grown into one of the largest programs at BCCDC, expanding to 1389 locations throughout B.C. and distributing over 98,000 kits as of May 2018.[2] In our interview, Dr. Buxton tells us about her career in public health, her thoughts on the current fentanyl crisis, and the next steps in combatting it.

How did you get involved in public health? What do you like about this specialty?

Before coming to Canada in 1998, I had practiced as a family physician in the U.K. for seven years. Though I enjoyed family practice, I wanted to take a step back and see how we could improve the health of the population rather than just the individual patient. Therefore, I chose to do my mandatory year of residency in public health. I feel like I have been able to make a difference on a larger scale than had I stayed a family doctor. In particular, I enjoy the variety of work in public health: dealing with infectious diseases, epidemics, and collaborating with a variety of stakeholders within governmental programs.

What advice would you give to students interested in this field?

My advice is to explore all the different areas of public health: advocacy, social determinants of health, prevention, and health promotion (to name a few). Talk to people in the field, conduct a research project, and do an elective. Appreciate the diversity of it; you can work in an academic environment, a local environment (such as a health authority), provincially (such as the BCCDC), nationally, or even internationally (with the World Health Organization) and abroad.

What has your experience been like in terms of starting the BCTHN program from scratch and then facing this surge in attention and demand brought on by the fentanyl crisis?

I feel very fortunate that we started BCTHN early in 2012, because it allowed us to have an established program and training materials developed before the crisis hit. When death tolls skyrocketed in 2016, we were forced to react and expand rapidly. We had to respond to a 17–fold increase in demand of naloxone kits within a year.[2] This was good, because that means the public knew naloxone could save lives and was buying into the program; however, it was a struggle at times to actually get as much naloxone out into the community as was needed.

Facing this public health emergency has definitely been a challenge. The public wants naloxone, because it is something concrete that they can do. However, there are many other interventions that we need to be looking at to prevent overdoses. Although the BCTHN can be seen as an after–the–fact, band–aid solution in some ways, it is a fabulous tool for engaging people. Peers have come forward and started talking about their drug use because someone handed them a naloxone kit. It has really started the conversation and been empowering for peers.

Why do you believe the fentanyl crisis has become so significant in B.C.?

I think there are two main reasons: prohibition of the drug and its toxicity. We saw that when oxycodone (OxyContin) was removed from the market in 2012, people were pushed to illegal substances. Oxycodone is a medication that is frequently crushed, snorted, and injected by people who use opioids illicitly (PWUOs).[3]

Prohibition is simply not effective and when a certain drug is made unavailable, PWUOs will seek alternatives. The high potency of fentanyl compared to other opioids means that a small package can contain enough fentanyl to make thousands and thousands of tablets when cut with other substances. Previously, small packages could not be opened or assessed by the Canada Border Services Agency, and this made it difficult to discover and seize illicit fentanyl. Powerful analogues such as carfentanil (one hundred times more potent than fentanyl) are even easier to smuggle undetected.[4] Because of the illegal market and the prohibition, there is no quality control on dosage and this has led to unintentional fatal overdoses.

What do you believe are the next steps to solving this crisis?

First, we have to improve our messaging to PWUOs about policy changes. I am concerned that peers are reluctant to call for help if they are using drugs together and someone overdoses. However, we have the Good Samaritan Drug Overdose Act, a federal act, which means that anyone calling for 911 for themselves or someone else, or anyone else at the scene when emergency help arrives, will not be charged for simple drug possession.[5] We have to get the message out that if you are going to use, make sure you are with someone who can call for help. Second, we have to improve access to safe injectable opioid agonists, such as methadone or suboxone. There has to be an alternative to heroin and fentanyl so that people are not going to the illegal market. Heroin–assisted treatment trials such as the Study to Assess Longer–term Opioid Medication Effectiveness (SALOME) and The North American Opiate Medication Initiative (NAOMI) have shown that injectable hydromorphone and diacetylmorphine are safe when taken in a clinical setting.[6,7] Finally, we have to reduce the stigma around people using drugs. Unfortunately, stigma can prevent PWUOs from accessing therapy, and can affect the attitudes of healthcare workers and the quality of care delivered. By making naloxone kits and training commonplace in B.C., we are hoping BCTHN can not only

[1]MD Program, Faculty of Medicine, University of British Columbia, Vancouver, BC, Canada

Correspondence
Sympascho Young (sympascho@alumni.ubc.ca)

reduce the amount of fatal overdoses, but also reduce the shame and stigma surrounding drugs.

Conclusion

At the time of this interview, despite the declaration of a public health emergency in April 2016 and rapid scale up of the BCTHN, death tolls have only grown. In 2017, there were 1436 illicit drug overdose deaths, which represents a 44% increase compared to 2016.[8] Dr. Buxton's BCTHN program has been a critical intervention that has saved thousands of lives, but solving this crisis requires major upstream change: reducing stigma, improving access to regulated opioids, educating PWUOs about policy changes, and prescribing opioids responsibly. As doctors and health advocates, we will all have a role to play in solving this unique public health crisis.

Disclosure

Sympascho Young works with Dr. Jane Buxton and the BCTHN program in a research capacity.

References

1. BCCDC. Public health emergency in BC [Internet]. B.C., Canada: BCCDC; 2017 Jan 18 [cited 2017 Dec 14]. Available from: http://www.bccdc.ca/about/news-stories/stories/public-health-emergency-in-bc
2. BCCDC Harm Reduction Program. Toward The Heart [Internet]. B.C., Canada: BCCDC Harm Reduction Program; 2012 [updated 2018; cited 2018 May 10]. Available from: http://towardtheheart.com/
3. Howlett K, Giovannetti J, Vanderklippe N, Perreauxa L. A Killer High: How Canada got addicted to fentanyl [Internet]. Toronto, Canada: The Globe and Mail Inc.; 2016 April 8 [updated 2017 Nov 12; cited 2018 Mar 10]; Available from: https://www.theglobeandmail.com/news/investigations/a-killer-high-how-canada-got-addicted-tofentanyl/article29570025/
4. B.C. Gov News. Lab test confirms carfentanil is being ingested [Internet]. B.C., Canada: B.C. Gov; 2017 [cited 2018 Mar 10]. Available from: https://news.gov.bc.ca/releases/2017HLTH0020-000224
5. Government of Canada. About the Good Samaritan Drug Overdose Act [Internet]. Canada: Government of Canada; 2017 May 4 [updated 2018 Mar 6; cited 2018 Mar 10]. Available from: https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/about-good-samaritan-drug-overdose-act.html
6. Oviedo-Joekes E, Nosyk B, Brissette S, Chettiar J, Schneeberger P, Marsh DC, et al. The North American Opiate Medication Initiative (NAOMI): profile of participants in North America's first trial of heroin-assisted treatment. *J Urban Health*. 2008 Nov;85(6):812–25.
7. Oviedo-Joekes E, Marchand K, Lock K, MacDonald S, Guh D, Schechter MT. The SALOME study: recruitment experiences in a clinical trial offering injectable diacetylmorphine and hydromorphone for opioid dependency. *Subst Abuse Treat Prev Policy*. 2015 Jan;26;10:3.
8. The Coroners Service of British Columbia. Statistical Reports into B.C. Fatalities [Internet]. B.C., Canada: The Coroners Service of British Columbia; [updated 2018 May 10; cited 2018 May 11]. Available from: https://www2.gov.bc.ca/gov/content/safety/public-safety/death-investigation/statistical-reports