Primary care and the RCMP

Unexpected partnership in opioid harm reduction

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Canada is in the midst of a national opioid overdose crisis, particularly in British Columbia (BC). In 2017, 1448 British Columbians died of illicit drug overdose.[1] Fentanyl was detected in 84% of cases, and carfentanil, the potent analogue of fentanyl commercially used to tranquilize elephants, has been detected in all 5 health authorities in BC.[1]

We practise at a primary care clinic located in Chilliwack, BC, which is approximately 100 km from Vancouver, with a population of a little more than 83000. Our clinic provides longitudinal care for complex unattached patients in the Chilliwack area, and thus has a large population of patients with addiction or opioid use disorder. In April 2016, our clinic became a site for the BC Centre for Disease Control's Take Home Naloxone (THN) program, which provides naloxone kits at no cost to people, or friends and family members of people, at risk of opioid overdose.[2] As of May 15, 2018, 1389 THN sites in BC had distributed more than 98000 kits, of which more than 22000 have been used to reverse opioid overdose.[3]

Valuable ally against the opioid crisis

Despite our clinic's proximity to the at-risk population in downtown Chilliwack, initial uptake of the program was low, likely because many of these patients typically do not access primary care services. Therefore, we sought external stakeholders to help spread the word regarding the THN program. Furthermore, we noted that in Banjo and colleagues' evaluation of the BC THN program, 2 officers from the Vancouver Police Department who were interviewed expressed concern that naloxone might promote illegal activities.[4] Also, in that same study, some of the program's clients (people who used opioids and received the kit) reported that they had had their naloxone kits confiscated by police.[4] To address these concerns, we reached out to the Chilliwack Royal Canadian Mounted Police (RCMP) Detachment to offer education about and demonstrate the use of THN kits. This was fortuitous, as it coincided with RCMP officers being permitted to carry naloxone nasal sprays.

Through initial conversations with the Community Policing Corporal of the Crime Prevention Unit and the Inspector of the Chilliwack RCMP Detachment, we received permission to provide educational sessions to each of the 4 watches. These sessions were initially planned to be 5 minutes to provide just the key points about fentanyl and naloxone. However, the sessions quickly broadened to 30 minutes based on members' interest in opioids and the THN program, including how to administer naloxone intramuscularly should the need arise. We acknowledge this interest was at least partially out of self-interest in case an officer were exposed to fentanyl; for example, one member recalled an occasion where a suspect threw a white powder (which turned out to be fentanyl) in his direction as a diversion. A recent position statement from the American College of Medical Toxicology and American Academy of Clinical Toxicology provides recommendations to prevent occupational exposure to fentanyl but states that "the risk of clinically significant exposure to emergency responders is extremely low."[5] Our educational sessions were jointly attended by members of the Drug Section of the Crime Reduction Unit who provided context as to the availability and content of illicit drugs in the area, including fentanyl.

Our local RCMP detachment has proved to be an invaluable ally in the fight against the opioid crisis, and we have been impressed with its dedication to harm reduction and empathy toward vulnerable people. This partnership has also been mutually beneficial. We were able to empower members to watch for signs of opioid overdose and administer naloxone if necessary, provide education, and dispel myths regarding naloxone, fentanyl, and other substances found in samples of confiscated drugs (eg, carfentanil, W-18 [1-(4-nitrophenylethyl) piperidylidene-2-(4-chlorophenyl) sulfonamide]). In turn, they were able to spread the word regarding fentanyl, naloxone, and the THN program to vulnerable individuals who might not access health care services. Additionally, they taught us the local "street" terms for illicit drugs so that we could use them when interacting with our patients, as well as connected us with key community stakeholders who might witness an overdose on their premises or who are at risk of being exposed to fentanyl. Through this, we identified a much-needed gap in community knowledge regarding the THN program and fentanyl in general. While working with the Community Policing Corporal, we met with multiple key stakeholders who were keen to learn more about fentanyl and naloxone. These stakeholders included BarWatch (a group of local bar and restaurant owners and managers), the Public Safety Advisory Committee (local members from city council, the fire department, the ambulance service, and the school board who were focused on current or emerging public safety issues), a drop-in shelter for youth, the local hospital psychiatry unit, and even the Provincial and Supreme Courts of BC. These joint sessions with RCMP members provided a unique, coordinated message: we (as the pharmacist

and physician) discussed the pharmacologic effects and therapeutic uses of fentanyl and naloxone, while RCMP members discussed the content, availability, and special handling (for litigators) of illicit drugs.

Shared responsibility

Opioid harm reduction is the responsibility of all primary care providers, including family physicians, nurse practitioners, and pharmacists (both in community pharmacies and in family health teams), and partnering with local law enforcement has led to unanticipated benefits. While some might not perceive this issue to be relevant to law enforcement, we would argue the opposite. Preventing opioid-related overdose deaths directly relates to the protection of the public. Also, law enforcement members are on the front lines interacting with those with addiction or mental illness who are at high risk of opioid overdose. In a 2016 study, Deonarine and colleagues conducted a focus group with 2 law enforcement officers in BC.[6] When discussing whether administering naloxone would impinge on the responsibility of other emergency services, one officer noted that "ensuring that lives are saved is a shared responsibility of all emergency services, including the police."[6] These officers also acknowledged that arrests for drug possession in an overdose situation might not serve the public good, as it might dissuade some individuals from calling 911. This aligns with the Government of Canada's recently passed Good Samaritan Drug Overdose Act, which provides immunity from simple drug possession for individuals who witness an overdose and call 911.[7] The officers in the Deonarine and colleagues study stated that naloxone did not have any street value[6]; however, we have recently learned that some dealers in our area are buying naloxone kits presumably to have on hand in case one of their clients overdoses. Regardless, not all law enforcement officers are aware that naloxone is still essential in case of an opioid overdose and therefore should not be confiscated. Finally, the officers expressed concern over legal liability and jurisdictional issues with administering naloxone; however, this matter appears to have been resolved (at least among the RCMP), as they are now permitted to carry and administer naloxone via nasal spray, but this is primarily for member safety.

As a call to action, all primary care providers should be more involved in opioid harm reduction. This problem is too great to be left to community outreach and mental health services, which are chronically underresourced in many areas. First, we would advocate that any clinic that provides care to those with addiction or opioid use disorder becomes a site that distributes THN kits, if available. If your jurisdiction does not have a THN program, then lobby your Members of the Legislative Assembly to institute one. Second, meet with local law enforcement to share information regarding fentanyl, naloxone, and the composition of the illicit drugs in your area. We were fortunate, as our local RCMP detachment identified the need for more education among its members and was engaged in the dissemination of education. However, this might not be the case with all jurisdictions—some law enforcement services might demonstrate a lack of engagement owing to competing priorities or perception that this crisis is not within their mandate. However, based on our experience, the value of this relationship is worth the effort to overcome these challenges. Third, reach out to community stakeholders to conduct joint educational sessions with law enforcement (and other potential collaborators such as public health officials, emergency medical service members, or emergency department physicians) to educate the public regarding addiction, opioid overdose, and naloxone. The THN program is only a small contribution to a much larger comprehensive harm-reduction strategy, which includes needle exchange programs, safe consumption sites, opioid agonist therapy clinics, and education for the public and government to help reduce the stigma associated with addiction and allocate much-needed resources to this crisis.

If you are unsure of where to start, we recommend reaching out to your local law enforcement to offer education; law enforcement officials are on the front lines of this public health emergency, and hopefully, as was our experience, they will be open and receptive to partnering in the provision of care to this vulnerable population.

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Competing interests
None declared

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