MAP Centre for Urban Health Solutions

REPORT

# EXPERIENCES OF OVERDOSE AMONG PEOPLE WHO INJECT DRUGS IN THE CITY OF TORONTO

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Toronto continues to experience a devastating overdose crisis. In Toronto, over 1600 people have died from overdoses related to taking opioids in the past five years [1]. In this study, we wanted to examine the experience of overdose from the point of view of people who inject drugs. There is an urgent need to understand the effect of experiencing, witnessing, and responding to overdoses on people who inject drugs, especially when these events are happening over and over again. We believe that a better understanding of how these events affect the physical and mental health of people who inject drugs is important for designing interventions that account for the traumatic nature of overdose events and their harms to health. Ultimately, this understanding will help improve equity in health.

In this report, we summarize what people who inject drugs in Toronto told us about their overdose experiences. We are interested in what happened at the time of their overdose and how others responded to their overdose. In our next report, we will focus on the experiences of overdose among people experiencing homelessness. In our fourth and final report, we will summarize the impacts of experiencing, witnessing, and responding to overdoses on people who inject drugs.

## WHAT WE DID

The Impacts of Overdose Study is a community-based research project. Our aim is to better understand the overdose experiences of people who inject drugs in Toronto. We are especially interested in how overdoses have an impact on grief and loss. We brought together a Community Advisory Team of people with living and lived expertise of drug use, researchers, and service providers to design our surveys, interviews, and help interpret our findings.

In early 2019, we surveyed 249 people who inject drugs. We recruited people who inject drugs at four Toronto harm reduction programs that offer supervised consumption services (SCS). Researchers with living and lived expertise of drug use conducted the surveys. The surveys included questions about overdose experiences, naloxone use, emotional reactions to overdose experiences, coping strategies, and the need for supports for dealing with grief and loss.

We also interviewed 17 people who had completed the survey, had experienced an overdose, and had witnessed or responded to another person's overdose. We asked about these experiences and their impacts. We also asked about what tools and services people found helpful to support them. We identified common themes across the interviews, including experiences with first responders and hospital staff.

It is important to note that our data relied on self-reports of overdose experiences. Self-reported overdose experiences may be under-reported given the nature of overdoses and loss of memory following an overdose. It is also important to note that while much of the information we present in this report is focused on the number of overdoses events, we acknowledge that people's overdose experiences are highly diverse based on the severity of the overdose, underlying or new health complications, the cumulative impact of overdoses, amongst other factors.

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# WHO WE SPOKE TO

## We did 249 surveys with people who inject drugs

Average age: **42**

### RACE/ETHNICITY :

- **63%** Identified as White
- **33%** Identified as First Nation, Metis, or Inuit
- **6%** Identified as Black
- **3%** Identified as Asian
- **3%** Identified as another racial or ethnic identity
- **10%** Identified as two or more racial or ethnic identities

### SOCIAL DEMOGRAPHICS:

- **89%** Received social assistance through Ontario Works or Ontario Disability Support Program
- **66%** Experienced homelessness in the last 6 months
- **26%** Incarcerated in the last 6 months

### DRUG USE/OVERDOSE:

- **64%** Injected drugs daily
- **46%** Most often injected fentanyl
- **33%** Currently prescribed methadone or suboxone
- **9%** Currently prescribed other opioids

*Note: Data on racial/ethnic identity was missing for 9 people. Also, percentages within the section on race/ethnicity sum to greater than 100% because people could select multiple racial/ethnic identities.*

# WHAT WE FOUND

### *Circumstances of overdose*

In the survey, the most common drug used before overdosing was fentanyl, and it was usually used by injection. Overdoses most commonly occurred in someone else's apartment or house.

### SETTING:

- **29%** Overdosed in someone else's apartment
- **20%** Overdosed in own apartment/house
- **18%** Overdosed in SCS or overdose prevention site (OPS)
- **10%** Overdosed in public bathroom
- **8%** Overdosed in street/alley
- **3%** Overdosed in shelter
- **2%** Overdosed in park
- **10%** Overdosed in other setting
- **18%** Overdosed alone

### DRUGS USED:

- **74%** Fentanyl
- **33%** Methadone or suboxone
- **24%** Crack
- **22%** Heroin
- **17%** Alcohol
- **13%** Cocaine
- **10%** Benzodiazepines e.g., Ativan, Xanax, klonopin, Valium
- **8%** Prescription opioids

### ROUTE OF USE:

- **83%** Injected
- **12%** Smoked
- **5%** Inhaled
- **3%** Ingested

*Note: Percentages within each section sum to greater than 100% because survey participants could select more than one item.*

In the interviews conducted with a sub-sample of people surveyed, most people's overdoses also involved fentanyl. Some people spoke about how they did not expect fentanyl in their drugs. The overdoses often occurred when they were alone at their own home, with someone else at home, or at a friend's home. People who overdosed alone described being found by their neighbours, family, strangers, harm reduction workers, or housing staff. Other overdose locations included parks or public indoor spaces such as a stairwell of a rooming house.

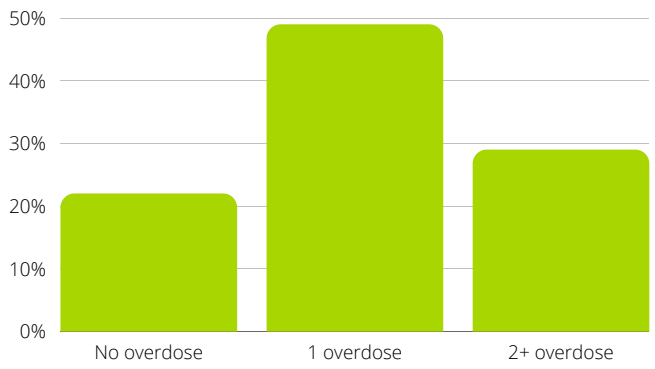
***"And one was by myself, ah, in a stairwell in Moss Park, at five o'clock in the morning"***

When asked about the use of opioid agonist treatments (OAT) like methadone and buprenorphine (Suboxone), very few people interviewed reported having an active prescription for OAT or for other opioids at the time of overdose. Only one person interviewed reported being prescribed methadone at the time of overdose and nobody reported being prescribed other OAT (buprenorphine or slow-release oral morphine). We also spoke to one person who had recently left a withdrawal unit, with no prescription for OAT, and then overdosed at home alone a few days later.

### *Own overdose frequency*

The experience of overdose was extremely common among the people we spoke to. Concerningly, 49% of all people surveyed experienced one overdose in the past 6 months, and 29% experienced two or more overdoses (Figure 1). Most people we interviewed had also experienced more than one overdose.

**Figure 1. Own overdose frequency**




### *Gender and overdose frequency*

In the survey, 52% of people who self-identified as women and 47% of people who self-identified as men had experienced at least one overdose in the past 6 months. Additionally, 31% of people who self-identified as women and 29% of people who self-identified as men reported experiencing two or more overdoses in that time period (Table 1).

**Table 1. Own overdose frequency (last 6 months) and gender**

| | People self-identifying as a man (n=114) | People self-identifying as a woman (n=56) | People self-identifying as non-binary or other genders (n=4) |
|---|---|---|---|
| No overdose | 53% | 48% | 50% |
| 1 overdose | 18% | 21% | 25% |
| 2+ overdoses | 29% | 31% | 25% |

*Note: Data on gender identity was missing for 75 people.*

### *Other characteristics of people surveyed and overdose frequency*

We noticed different patterns of overdoses among different groups of people surveyed. Notably, a substantial proportion of our sample reported experiencing two or more overdoses, which varied by social and demographic characteristics.

Around 20% of people who self-identified as White, Indigenous, and other racialized identities reported experiencing one overdose in the previous 6 months. Higher proportions of people who self-identified as White and people who self-identified as Indigenous experienced two or more overdoses (Table 2).

**Table 2. Own overdose frequency (last 6 months) and racial/ethnic identity**

| | People self-identifying as white only (n=135) | People self-identifying as Indigenous (n=80) | People self-identifying as other racialized identities* (n=24) |
|---|---|---|---|
| No overdose | 56% | 41% | 66% |
| 1 overdose | 19% | 21% | 17% |
| 2+ overdoses | 25% | 38% | 17% |

**Includes all people self-identifying as other racialized identities who did not identify as Indigenous.*

Among people who injected fentanyl daily, 44% reported experiencing two or more overdoses in the past 6 months. Rates of OAT were relatively low, with about one-third of people surveyed having a current methadone or suboxone prescription. About half of the people with a methadone or suboxone prescription reported no overdose experiences in the past 6 months; about one-third reported experiencing two or more overdoses in that time period. Among people with a current prescription for other opioids, 54% reported no overdose experiences in the past 6 months. However, it is concerning that 23% experienced two or more overdoses (Table 3).

**Table 3. Own overdose frequency (last 6 months) and drug use characteristics**

| | Inject fentanyl daily (n=117) | Currently prescribed metadone or suboxone (n=82) | Currently prescribed other opioids (n=22) |
|---|---|---|---|
| No overdose | 40% | 46% | 54% |
| 1 overdose | 16% | 18% | 23% |
| 2+ overdoses | 44% | 36% | 23% |

About one-third of people experiencing homelessness experienced two or more overdoses. Among people who had accessed detox or drug treatment in the past 6 months, 44% experienced two or more overdoses. Among youth, 54% experienced two or more overdoses in the past 6 months. However, this should be interpreted with caution due to the small number of youth surveyed. (Table 4).

**Table 4. Own overdose frequency (last 6 months) and social characteristics**

| | Experienced any homelessness in the last 6 months (n=164) | Incarcerated in the last 6 months (n=64) | Accessed detox or drug treatment in the last 6 months (n=41) | Youth (n=13) |
|---|---|---|---|---|
| No overdose | 46% | 44% | 32% | 38% |
| 1 overdose | 19% | 30% | 24% | 8% |
| 2+ overdoses | 35% | 26% | 44% | 54% |

### *Overdose response*

In the survey, most people who overdosed were given naloxone. In most situations, the naloxone was given by a friend (Table 5). Experiencing withdrawal after naloxone was common. Less than half of people surveyed reported an ambulance being called or going to the emergency room in an ambulance.

**Table 5. Overdose response at last overdose in 6-month period perior to survey**

| | n=121 |
|---|---|
| Ambulance called | 39% |
| Went in ambulance to emergency room | 31% |
| **Naloxone administered (n=75)** | **75 (62%)** |
| Naloxone given by a friend | 45% |
| Naloxone given by a SCS/OPS staff | 16% |
| Naloxone given by a spouse/partner | 11% |
| Naloxone given by a paramedic | 5% |
| Naloxone given by other (e.g., worker, stranger, acquaintance, other) | 23% |
| Experienced withdrawal after naloxone | 67% |

In the in-depth interviews, people told us that in most situations 911 was called, paramedics responded, and people were taken to the hospital. Overdose responses commonly included the use of naloxone by a friend, partner, bystander, or paramedics. One person refused to go to the hospital. Some people mentioned that 911 was not called during overdose situations because they or others were afraid of police coming to the overdose along with paramedics.

***"…I think, he has, you know, a criminal record and stuff like that"***

The experiences with police and paramedics who responded to overdoses varied. Some people reported mistreatment by police, with police asking people about warrants and using threats to get them to go to the hospital.

***Interviewer: …How were the cops and the paramedics?***

***Person interviewed: Cocky, ah 'If you don't go, we'll place you under arrest.'***

### *Experiences at the hospital following an overdose*

Most of the people interviewed experienced withdrawal after receiving naloxone. At the hospital, only one person received medication to manage their withdrawal symptoms. Nobody was offered OAT or a referral to a substance use treatment program. We spoke to one person who ended up using drugs in the hospital to feel better and two others who left early due to untreated withdrawal symptoms.

**"Nothing. I asked for something. I asked for a couple of Tylenol or Advil, and one of the nurses stood there and said 'Well, there's no drug seeking here.'"**

Most people interviewed also reported negative experiences with healthcare providers after their overdose, including the experience of stigma and discrimination from hospital staff. Several people described wanting to leave the hospital due to discrimination and not wanting to be isolated and strapped to a hospital bed.

**"Automatically, I'm also a crack smoker, and I sell my body. Automatically. And they treat you with such disdain, it's sickening. It's sickening how they treat you. You talk about the stigma? They add it to you. They are horrible. They don't offer any counselling. They don't offer any drug treatment. They don't offer any detox. They offer nothing, but the door, as fast as they can get you out of there. They left me lying in my own shit."**

# WHAT WE RECOMMEND

### *Potential actions*

Based on what we heard about the circumstances of overdose and people's post-overdose experiences with paramedics, the police, and at the hospital, there is urgent need for action to support people who inject drugs. People who are experiencing multiple forms of oppression related to the history and continuing experiences of colonialism in Canada, anti-Black racism, and not having a home, are reporting more frequent overdoses. Despite existing recommendations [2], there continues to be a lack of culturally safe and appropriate services for Indigenous people who inject drugs. Culturally safe supports for racialized and Indigenous people who inject drugs are crucial when planning and implementing each of the recommended actions below. For example, this includes supporting the development of or ensuring access to programs and services that are specific to and led by racialized and Indigenous peoples and equitable employment practices of racialized and Indigenous workers supporting people who inject drugs.

**Recommendation #1: Increasing access to harm reduction services particularly within places people live and in the shelter system.**

Two-thirds of people in our survey had experienced homelessness in the past 6 months. The scale-up of harm reduction services in the shelter system including the implementation of OPS and comprehensive harm reduction supports has been slow. During the COVID-19 pandemic, there have been increases in the number of fatal and non-fatal overdoses in the shelter system including emergency shelters, shelter hotels, and respites [3]. People surveyed and interviewed often experienced overdoses in their own home or someone else's, and several reported using drugs alone.

- **Expanding harm reduction services including integrating low-threshold OPS and SCS in spaces where people live is recommended**. Integration of such services in Toronto Community Housing buildings with high numbers of overdoses, in shelters, respites, sheltering hotels, and supportive and rooming houses are important ways to keep people safe in the spaces where they live and stay.
- **Scaling up innovative options for low-threshold harm reduction services in residential settings (also known as "Satellite Sites") to keep people safe when using alone or in their own homes**. Front-line workers providing essential services like Satellite Sites should be paid fairly and have access to health and social supports [4].

- **Exploring virtual harm reduction services (sometimes called 'spotting' services where a person using drugs at home or another location is monitored virtually by someone) or apps that people can use to automatically alert emergency medical services when they are using drugs alone at home [5].** Harm reduction programs, shelters, respites, and supportive and rooming houses should provide access to phones for people to access virtual options.
- **Addressing barriers that prevent people from accessing SCS and OPS** - including the need to increase spaces, hours of operation, and ensure that services are available in all areas of the city.

**Recommendation #2: Providing access to a range of low-barrier treatment options and supports available for people who inject drugs.**

Our findings suggest that OAT options such as methadone or buprenorphine are not reaching the most marginalized people who may benefit from such medications and more supports are needed. Most people surveyed and interviewed spoke of using fentanyl, with a high frequency reporting that they inject fentanyl daily. Recent recommendations [6], point to the difficulties of managing withdrawals and cravings with OAT in the current context of increased fentanyl in the drug supply. During the COVID-19 pandemic, specific guidance for OAT was released that addresses some of the barriers people face in accessing and staying on OAT, including daily observed doses in the pharmacy [7]. A continued focus on addressing the barriers to OAT treatment is needed. There is also a strong need for a continuum of services for people who are not interested in or have not responded to traditional OAT models, including the scale-up of safer opioid supply programs.

**Recommendation #3: Improving the quality of care offered to people who inject drugs.**

The people in our study overwhelmingly experienced stigma and discrimination when interacting with the healthcare system following an overdose. At the hospital, only one person was offered medication for their withdrawal, and none were offered OAT. Almost half of the people who accessed detox or drug treatment in the past 6 months experienced two or more overdoses. It is critical that people are offered supports and treatment for opioid withdrawal when leaving detox or drug treatment, in the emergency department or when admitted to hospital to increase their ability to engage in treatment plans.

> **" So, I think that a good hospital visit would probably look like just, just a little bit more ah, just a little bit more understanding, like, a little bit more patience, and, you know what I mean? I don't, what would be the word for it? Just a little bit more, um, I don't want to say sympathetic, because I don't want them to be sympathetic, but I just, I would want them to understand, that you know, it's, it's scary for the person too. You know what I mean? And, like I said, there's a stigma with this…"**

Previous studies have examined the provision of OAT (particularly buprenorphine-based treatments) in the emergency department [8,9]. The provision of buprenorphine to interested patients following an overdose should be explored by Toronto-area hospitals. Additionally, emergency departments should provide naloxone kits and referrals to a range of services for people following an overdose, including OAT, harm reduction interventions, and clinics offering safer opioid supply programs. There is also a need to develop comprehensive medical care models including low-barrier substance use treatment for people experiencing homelessness.

**Recommendation #4: Increasing efforts that focus on improving structures to reduce harms for people who inject drugs.**

While there was a high frequency of fentanyl and poly-substance use among people surveyed and interviewed, the overall community context and the volatility of the unregulated drug supply has drastically shifted since data was collected [10]. This is in part due to the intersection of the COVID-19 pandemic, the overdose crisis, and the crisis from the lack of affordable housing. Our Community Advisory Team pointed to the gap in interventions available to address the ways in which these 3 public health emergencies are intersecting in the current moment. In particular, strategies tend to focus on addressing and responding to potentially fatal overdoses, rather than intervening to prevent the occurrence of an overdose in the first place through safer supply programs, compassion or buyer's club models, or the introduction of a regulated drug supply. Additionally, decriminalization and legalization (beyond safer opioid supply programs) need to be at the forefront of dialogue on interventions to address the crisis of drug poisonings, due to the documented harms from criminalization on people who use drugs.

## CONCLUSION

Our findings show that many people who inject drugs are experiencing multiple overdoses, likely due to the high frequency of fentanyl use in the context of an unregulated, toxic drug supply. Overdoses are happening at their own or someone else's home. We also note a link between people who overdosed two or more times and the experience of multiple forms of oppression. Additionally, experiences of stigma and discrimination were common within healthcare settings. It is important to note that data presented in this report was collected prior to the COVID-19 pandemic. Since the pandemic started, there has been a large increase in fatal overdoses as well as continued volatility in the unregulated drug supply with increases in benzodiazepines and stimulants contributing to fatal overdoses [10], and reduced access to health, social services, and supports. Data presented in this report highlight the urgent need to escalate availability and access to a range of low-threshold harm reduction and treatment options, and the overall need to reduce stigma and discrimination towards people who use drugs within the healthcare system.

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