

The Hidden Epidemic

Clarence Chant

DOI: [10.4212/cjhp.v75i2.3278](https://doi.org/10.4212/cjhp.v75i2.3278)

Even before the COVID-19 pandemic, the opioid overdose epidemic was causing significant loss of lives. Unfortunately, while the world's collective attention has been focused on various aspects of the pandemic, the opioid epidemic continues, and its impact is increasing. As just one example, a recent study reported an increase of 135% (and up to 320%) in deaths from opioid overdoses during the first months of the COVID-19 pandemic in a single Canadian province.¹

Excessive and potentially inappropriate prescribing of opioids and their diversion from health care institutions have been cited as factors contributing to the opioid epidemic. Given the increased severity of the opioid crisis, more studies and innovative solutions are urgently needed. In this issue of the *Canadian Journal of Hospital Pharmacy (CJHP)*, Ti and others² describe a unique pilot project for a hospital-wide opioid stewardship program. Similar to the more prevalent antimicrobial stewardship programs (which Accreditation Canada now designates as Required Organizational Practices), this opioid stewardship program targeted specific populations and medications, providing audit and feedback about the appropriateness of prescribing. In the first year, more than 1500 recommendations were made for several hundred patients. Unfortunately, no outcome data (in terms of reduced usage, in morphine equivalents) are provided in the article. Other innovative programs have previously been reported, such as a prescribing force function to reduce the quantity of postoperative pain medications administered.³ Although each of these studies tackled only one aspect contributing to the multifactorial opioid epidemic, these types of research offer important insights.

As for the second contributor, that of diversion of opioids from hospitals by staff members, research and understanding are not advancing in the same manner. Until recently, diversion was not a welcome topic of conversation. One recent review of 5 years of Health Canada data showed a substantial number of reports of loss of controlled substances—142 420 in all—from across the country in all types of facilities, with hospitals accounting for 17% of these losses.⁴ What is more concerning is that the reasons for the losses were largely unexplained, at 33.4%! To further compound the problem, disciplinary actions in general, including those related to diversion by hospital staff, are rarely reported to regulatory colleges, despite it being a mandatory

requirement in many jurisdictions. Also in this issue of the *CJHP*, Fung and others⁵ corroborate these general observations of under-reporting through a qualitative study, using semistructured interviews with pharmacy directors across the country. The authors found five themes for under-reporting to regulatory bodies, namely a robust organizational discipline process, union representation, preference for remediation, promotion of a practice environment that promotes competency, and unclear regulatory requirements. While these themes are logical and reasonable, they do not help in understanding the issue of opioid diversion by staff, because it is difficult or impossible to devise solutions to a problem that is largely hidden and unknown.

Despite the fact that the American Society of Health-System Pharmacists⁶ and the Canadian Society of Hospital Pharmacists⁷ have published guidelines to help detect and deal with diversion in hospitals, there remain numerous institutions, especially in Canada, that have not implemented a formal diversion committee or a fulsome program on this topic. Although opioid stewardship programs like the one described by Ti and others² borrow learnings from antimicrobial stewardship, many hospitals do not seem to have learned from the medication incident knowledge domain, whereby reporting of all medication incidents, even the near misses, is an essential pillar of system improvement to better patient care. Opioid diversion does lead to patient harm in many ways, not the least of which is that patients do not receive the pain management medications intended for them. A systematic review documented that opioid diversion and substitution of IV opioid with saline after self-injection of the opioid by a health care professional led to several outbreaks of gram-negative bacteremia and hepatitis C infections in patients who received the saline through contaminated needles.⁸ In fact, ISMP Canada has called for a culture shift related to opioid diversion, from one of personal failing that requires punishment and termination to one of open communication whereby system gaps can be better addressed, similar to the improved culture of reporting medication errors that has contributed to greater medication safety.⁹

So, perhaps there are really two hidden epidemics here: the opioid crisis and a crisis of diversion and under-reporting. If pharmacists and pharmacy technicians are

indeed champions of medication safety, then diversion prevention should become an openly discussed topic that is part of their daily work and is included in their respective school curriculums and research publications.

References

1. Gomes T, Kitchen SA, Murray R. Measuring the burden of opioid-related mortality in Ontario, Canada, during the COVID-19 pandemic. *JAMA Netw Open*. 2021;4(5):e2112865.
2. Ti L, Mihic T, James H, Shalansky S, Legal M, Nolan S. Implementation of an opioid stewardship program to promote safer opioid prescribing. *Can J Hosp Pharm*. 2022;75(2):113-7.
3. Clarke HA, Manoo V, Pearsall EA, Goel A, Feinberg A, Weinrib A, et al. Consensus statement for the prescription of pain medication at discharge after elective adult surgery. *Can J Pain*. 2020;4(1):67-85.
4. Fan M, Tscheng D, Hamilton M, Hyland B, Reding R, Trbovich P. Diversion of controlled drugs in hospitals: a scoping review of contributors and safeguards. *J Hosp Med*. 2019;14(7):419-28.
5. Fung A, Foong-Reichert AL, Houle SKD, Grindrod KA. Reasons for low regulatory body discipline rates for Canadian hospital pharmacists. *Can J Hosp Pharm*. 2022;75(2):97-103.
6. American Society of Health-System Pharmacists. ASHP guidelines on preventing diversion of controlled substances. *Am J Health Syst Pharm*. 2017;74(5):325-48.
7. *Controlled drugs and substances in hospitals and healthcare facilities: guidelines on secure management and diversion prevention*. Canadian Society of Hospital Pharmacists; 2019.
8. Schaefer MK, Perz JF. Outbreaks of infections associated with drug diversion by US health care personnel. *Mayo Clin Proc*. 2014;89(7):878-87.
9. Opioid diversion in hospitals — a safety concern. *ISMP Can Saf Bull*. 2020;20(8):1-4.



Clarence Chant, BScPhm, PharmD, BCPS, FCCP, FCSHP, is Senior Director, Pharmacy, Unity Health Toronto, and Adjunct Professor, Leslie Dan Faculty of Pharmacy, University of Toronto, Toronto, Ontario. He is also an Associate Editor with the *Canadian Journal of Hospital Pharmacy*.

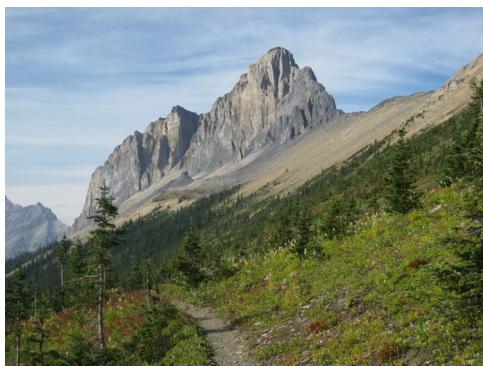
Competing interests: None declared.

Address correspondence to:

Dr Clarence Chant
Pharmacy Department
Unity Health Toronto
30 Bond Street, Room B0007
Toronto ON M5B 1W8

email: clarence.chant@unityhealth.to

ON THE FRONT COVER



Wapta Mountain, Yoho National Park, British Columbia

June Chen captured this photograph of Wapta Mountain in Yoho National Park with a Canon PowerShot SD1100 IS digital camera while hiking the Emerald Triangle trail.

June is a clinical pharmacist at the University of Alberta Hospital in Edmonton. She practices on the cardiac intensive care and cardiovascular surgery units. During the summer months, she enjoys hiking in the mountains, and all year round, she likes to dance contemporary jazz.

The *CJHP* would be pleased to consider photographs featuring Canadian scenery taken by CSHP members for use on the front cover of the Journal. Spring-themed photographs are needed, so get your cameras out! If you would like to submit a photograph, please send an electronic copy (minimum resolution 300 dpi) to publications@cshp.ca.