Community Opioid Plan

Leeds, Grenville and Lanark

April 19, 2018

Table of Contents

Section 1 Community Assessment

Situational Assessment Opioids in Leeds, Grenville and Lanark 3

Situation 1: Problematic Use of Prescription Opioids 9

Situation 2: Illicit Fentanyl in the Community 11

Situation 3: Potential for Overdose Cluster 13

Section 2 Appendices

Appendix A – Aces data for LGL December 2017 Data 15

Appendix B – Neonatal Abstinence Syndrome Data LGL 17

Appendix C – Overdose Reporting Tool 2017 LGL 18

Appendix D – PHO Data Opioid-related morbidity and mortality in LGL 19

Appendix E – PHO Data Male and Female Opioid Related Death, ED visit and hospitalization 21

Situational Assessment Opioids in Leeds, Grenville and Lanark

Situational Assessment Questions/Sub-Questions	Examples	Leeds, Grenville and Lanark – Situational Assessment
1. What is the Situation?		**Situation 1: Problematic Use of Prescription Opioids –** Problematic opioid misuse and abuse in the community has been present for many years. All parts of Ontario have high levels of prescription opioids to manage pain. People who are prescribed opioids may become dependent requiring more and more drugs. Opioid prescriptions may also be diverted to others. The public also has access to prescription opioids through illicit drug dealers. Problematic opioid use can greatly interfere with all aspects of living – self-care, relationships, family, school, work – and can lead to overdose and death. **Situation 2: Illicit Fentanyl in the Community** – Recently the opioid problem has intensified because of the increased presence of illicit fentanyl which is being cut into other drugs or replacing them making it difficult for users to know exactly what they are taking. A small amount of fentanyl can cause an overdose with respiratory depression and possibly death. Overdoses linked to opioids (and others probably linked to opioids) have occurred in Lanark, Leeds and Grenville. **Situation 3: Potential for Overdose Cluster** – Given the presence of illicit fentanyl in the community, there is an increased risk of mass casualties occurring within the community – either several people in one locale or in a short time span. This has the potential to tax first responders and hospital resources.
a. What impact does the current opioid situation have on health outcomes, quality of life and other societal costs?	•ED visits •EMS calls •Hospital admission •Use of addiction treatment services and non-urgent medical services •Neonatal abstinence syndrome •Motor vehicle collisions	Acute Care Enhanced Surveillance (ACES) data for Leeds, Grenville and Lanark (LGL): **December 2017 Data (Data Graphs in Appendix A)** • Total Opioid and Other Drug Toxicity- Related ED Visits for LGL Jan-Dec Each Year (2012-2017) • Total Opioid and Other Drug Related ED Visits for LGL by Month (2012-2017) • Total Opioid and Other Drug Toxicity-Related ED Visits for LGL by year and month (2017) **Neonatal Abstinence Syndrome Data LGL (Data Graph in Appendix B)** • Rate of Infants Aged 0-28 Days Hospitalized in LGL and Ontario for Neonatal Withdrawal Symptoms due to Maternal Use of Addictive Drugs (2007-2017) • https://www.cps.ca/en/media/when-a-baby-is-born-exposed-to-opioids **Overdose Reporting Tool LGL (Data Graph in Appendix C)** • Overdose Reporting Tool Opioid and Other Drug-Related Overdoses by Month, EMS Called and Naloxone

	•Incarceration •Police calls •Death (accidental versus suicide) •Child protection cases •Intergenerational impacts/ adverse childhood events	Administered LGL (2017) **Public Health Ontario (PHO) Data Opioid-related morbidity and mortality in LGL (Data Graphs in Appendix D)** • Cases of Opioid Related deaths by age group LGL 2016 • Cases of Opioid Related ED by age group LGL 2016 • Cases of Opioid Related hospitalizations by age group LGL 2016 • Cases of opioid Related morbidity and Mortality LGL 2015-2017
b. Which groups of people are at higher risk of health problems and poorer quality of life?	•Certain age groups (including youth, seniors, 35-44) •Males •Income quintile •Those with mental health issues •Those with substance use disorder •Those suffering chronic pain •Incarcerated individuals •Individuals using injection drugs •Those with previous non-fatal overdose	**Youth Drug Use Data** • Ontario Student Drug Use and Health Survey (OSDUHS) – "10.6% of Ontario students reported using opioid pain relievers (non medical)" (p. i) OSDUHS 2017 • http://www.camhx.ca/Publications/OSDUHS/2017/index.html **PHO Data Male and Female Opioid Related Death, ED visit and hospitalization (Data graphs in Appendix E)** • Cases of Opioid related ED visits by age group LGL 2016 • Cases of opioid related deaths by age group LGL 2016 • Cases of opioid related hospitalizations by age group LGL 2016 **Incarcerated individuals** http://healthunit.org/wp-content/uploads/Narcan_training_guide.pdf • "Statistically, there is an increased risk of overdose during the first 2 weeks after release from prison" (Revive Training Guide, p. 3) **Prescription of Opioids (Chronic pain)** http://www.hpepublichealth.ca/sites/default/files/ON%20Narcotics%20Atlas%20FINAL%20(December%202016).pdf • "The rate of individuals dispensed morphine was highest in South East LHIN at 211 per 10,000 population, nearly 3 times the rate in Ontario, within South East LHIN rates range across CSDs (Census Subdivisions) from 39 to 789 recipient's per 10,000 population" (Ontario Narcotics Atlas, December 2016, p. 11) • "The rate of individual dispensed hydromorphone was highest in South East and Champlain LHINs 356 and 372 per 10, 000 population respectively, both more than double the rate in Ontario" (Ontario Narcotics Atlas, December 2016, p. 18) **Mental Health and Substance Use disorders** http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11855-eng.htm

c. Which settings or situations are high risk, or pose a unique opportunity for intervention?	•Shelter •Emergency department •Addiction services •Jails and prisons •Schools •Primary care	• Lanark and Leeds and Grenville Interval house – Have identified a need for harm reduction services • Emergency Department – as evidenced by ED visit data related to opioids • Lanark, Leeds and Grenville mental health and addictions • Change Health Care – Brockville, Smiths Falls, Carleton Place and Solutions Healthcare • Upper Canada District School Board (UCDSB) and Catholic District School Board of Eastern Ontario (CDSBEO) • Primary Care – Community Health Centres • Prisons and Jails – Brockville Jail, STU • Lanark Mental Health • HARS • Lanark Housing • Victim Services Leeds, Grenville and Lanark • Cornerstone Landing – High-risk youth
d. How do local stakeholders perceive the situation? What is their capacity to act? What are their interests, mandates, current activities?	•Health care •Social service •Education •Enforcement •Political •Harm reduction	• Perth and Smiths Falls Emergency Department distributing naloxone • CDSBEO and UCDSB all have staff trained and naloxone kits available for first aid • Brockville, Gananoque and Smiths Falls police and OPP have naloxone and are trained • Lanark and Leeds and Grenville Interval house – Have identified a need for harm reduction services, they have safe injection/inhalation equipment
e. What are the needs, perceptions and supported directions of key influential community members, and the community-at-large?	•Community and political leader's attitudes towards harm reduction services •Community and political leader's attitudes regarding location of treatment and harm reduction sites	• There is a mix of attitudes and beliefs when it comes to drug use, addictions, harm reduction. • Harm reduction services/opioid issue continues to have challenges related to stigma/discrimination • MPP in Leeds & Grenville as well as Lanark (Steve Clark and Randy Hiller) have attended community meeting in the past as well demonstrating their agreement that this is a community issue. • South East LHIN has provided support that this is a concern by developing an opioid strategy and an opioid task force which includes key stakeholders from each of the communities. The LHIN through consultation with stakeholders has identified a need for rapid assessment and increase in mental health and addictions resources. • MOHLTC has provided an opioid strategy providing guidance under the 4 pillars of prevention, harm reduction, treatment and enforcement. • MOHLTC has created policy to support the distribution of naloxone by pharmacist, PHU, Fire, Police,

	•Community and political leader's opinions regarding drugs, drug use, and addictions •Physician attitudes regarding opioid prescribing •Provincial and national medical care policies •Provincial and national drug strategy policies	Community Agencies who provide service to high risk individuals. • MOHLTC has activated the EOC to assist in management of resources and timely response to issues related to opioid misuse. Biweekly teleconferences with a variety of stakeholders. Biweekly reports emailed out to share information and a link to resources. • Community at large is demonstrating an increase in awareness and knowledge of the issues related to opioid addiction and how they can play a role in responding to overdoses.
2. What influences are making the situation better and worse?		
a. What high-risk or negative health behaviours by various groups of people are affecting the situation?	•Pain management •Diversion of medications •Non-medical substance use •Injection use •Co-administration of multiple substances	• Physician prescribing pain management, tapering of opioids • Diversion of medications on the street-hydrophone, fentanyl patch (reported by clients) • Heroin, cocaine, illicit fentanyl , crystal meth (reported by clients) • Injection use: Smart Gear NSP – have increased distribution 2017- Full year 258,360 needles distributed • Cocaine laced with opioids –reported by police, drug seizure
b. Which underlying causes or conditions are	•Individual: e.g., poverty, adverse childhood events, mental health,	**Poverty** • Indicator for poverty is income. • LGL Community Health Profile http://healthunit.org/wp-content/uploads/Leeds_Grenville_Lanark_Community_Health_Profile.pdf

driving these behaviours (e.g. individual, community, organizational or system-level causes)?	experimentation •Community: e.g., social attitudes •Organizational: e.g., health services for pain, addiction, mental health •System-level: e.g., drug policies, health services/treatment policies	Some first responder reservation on naloxone administration Organizational: Limited services to treat addiction – sent to Ottawa or Kingston Addictions treatment in Lanark, Leeds and Grenville: • Addiction Treatment Referral Map • Lack of rapid assessment services • Lack of chronic pain control services within the community • Criminalization of drug use
c. Are there protective factors that can help avoid or alleviate the situation?	•Individual: e.g., resilience •Community: e.g., community supports •Organizational: e.g., health services – accessible, timely, evidence-based •System-level: e.g., health-based approach to drug use	Health equity/Basic Income • Support from local municipalities/counties • Good Samaritan overdose act • Police and Fire services trained in naloxone administration • Boards of Education supporting harm reduction/naloxone access in first aid kits • Community partners with high risk clients trained in distribution of naloxone kits- Ontario Naloxone Program Enhancement • Pharmacy/HU access to naloxone kits for people who use opioids or friends and family • Correctional services providing training and distribution of naloxone kits on discharge from correctional institutions. • Community partners providing satellite sites for distribution of harm reduction supplies • SELHIN task force to address rapid assessment and lack of mental health and addiction services • MOHLTC investment in Ontario Harm Reduction Distribution Program and Naloxone program • MOHLTC investment in activating EOC
d. Which strengths and weaknesses present in your organization may affect your course of action? Which		**Strengths:** • Community Harm Reduction Steering Committee – bringing community members together to approach the opioid issue. • MOH/Manager Health Unit has presented at Lanark Council and Mayors have written a letter to MOHLTC to support initiatives • MOH/Manager Health Unit has presented at many of the Emergency Control Groups in LGL and many of those engaged in emergency response planning have participated in creating/adopting Cluster Opioid Overdose response plan.

opportunities and threats in your environment may affect your course of action?		• MOH will be sharing quarterly a report to physicians providing them information on current status of opioid use/misuse and the strategies that are being used to address the issues. Report will be posted on HU website healthcare professionals page **Weaknesses:** • Organizational – limited staffing and resources • Rural community makes it challenging to reach certain populations • Challenges with getting "lived experience" involved

Situation 1: Problematic Use of Prescription Opioids

Situational Assessment Questions/Sub-Questions	Examples	Leeds, Grenville and Lanark – Situational Assessment
3. What possible actions can you take to address the situation?		**Situation 1 Problematic Use of Prescription Opioids**
a. What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community? What evaluation data are available for these activities?	•Prevention •Treatment •Harm reduction •Education •Surveillance / research •Enforcement	**<u>Activities – Prevention</u>** • Campaign targeted at public providing key prevention messages that also consider stigma and discrimination related to substance use • Prevention program in schools that target resiliency, connection with healthy adults and building skills to address risky behaviour • Look for opportunities to engage parents – social media, parent nights, Triple P Parenting Program • Root cause analysis that looks at the Social Determinants of Health (SDOH) as deficits in these areas can lead to misuse/abuse as means of coping • Advocacy for basic income as this could support some of the root causes under SDOH • Sensitivity training for all caregivers, agencies and organizations that work with high risk populations i.e. Bridges out of Poverty, social services, police, EMS, etc… • Create communication networks across agencies and organizations to facilitate sharing of information • Assist with Surveillance and Monitoring i.e. online overdose tool, provincial data bases - The HU has adopted an early warning/surveillance system that was created by Waterloo Crime Prevention. Community partners as well as the general public can fill out the Overdose Reporting Tool to report overdoses that do not present to acute care services i.e. ER. This tool provides "real time" reporting. - Epidemiologist monitors ACES daily as well as provides reports quarterly to be shared with community partners • Engaging primary care utilizing the support of champions **<u>Activities – Harm Reduction</u>** • Media campaign targeting those who misuse/abuse on overdose prevention • Promotion of Health Unit Harm Reduction Services within the tri-county • Develop partnerships to provide harm reduction services in areas of the tri-county that identify a gap in

		service in order to increase accessibility • Increase availability of education and training regarding harm reduction strategies for those who work with high risk population • Naloxone Kits to those who work with community at risk for opioid overdose i.e. Fire, Police, School Boards, Social Service • Explore how "Situation Table" can identify and assist those at high risk preventing further harm • Advocacy with provincial government to enhance funding for harm reduction strategies/services based on community need -AMOH meeting with assistant deputy minister -Opioid Overdose Prevention and Naloxone Access- Advocacy Letter CMOH • Recruiting those who are most impacted by opioid use/misuse as part of Community Harm Reduction Committee • Lanark MDS Event Invite –Icelandic Model Lanark County MDS is holding an event on February 9th 2018 to learn about the Icelandic model for reducing youth using substances. • Documents about the Icelandic model http://www.rannsoknir.is/wp-content/uploads/2015/06/Substance-use-prevention-for-adolescents-the-Icelandic-Model.pdf https://www.theatlantic.com/health/archive/2017/01/teens-drugs-iceland/513668/ **Activities – Treatment** • Establish referral pathways to mental health and addiction services with emphasis on access to rehab/detox, use of suboxone for short term addictions, methadone, trauma informed care -Participation in application for rapid assessment resources (SE LHIN Funding) • Education and awareness for community on referral pathway to addictions and mental health services • Education to primary care providers on using suboxone **Activities – Enforcement** • Increase understanding of the roles between enforcement and other community partners. Look for opportunities to work together i.e. drug court, Mental Health court • Partner with community agencies to create communication campaign to address "fear" of calling 911 promoting 911 as a resource i.e. video
b. What is the best-available evidence that exists to support various courses of action?		

Situation 2: Illicit Fentanyl in the Community

Situational Assessment Questions/Sub-Questions	Examples	Leeds, Grenville and Lanark – Situational Assessment
3. What possible actions can you take to address the situation?		**Situation 2: Illicit Fentanyl in the Community**
a. What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community? What evaluation data are available for these activities?	•Prevention •Treatment •Harm reduction •Education •Surveillance/research •Enforcement	**Activities – Prevention** • Create/communicate key messages tailored to a variety of target groups to communicate information related to illicit fentanyl and possible link to other opioids • Create opportunities for community discussions by offering town hall meetings **Activities – Harm Reduction** • Support individuals in the drug-using community to discuss risk of illicit fentanyl and identify how to reduce the risk • Create/communicate key messages related to illicit opioid misuse and abuse • Mass distribution of naloxone kits to those who are eligible either through Health Unit or Pharmacy • Distribute naloxone kits to those who work with communities at risk for opioid overdoses (Enhancement program) o September 2017 Harm Reduction Enhancement Program was initiated and community partners as identified in criteria for participation were invited to become be trained and become a key partner for training their clients. Eligible organizations include: Shelters, Outreach Organizations, AIDS Service Organizations, Community Health Centres, Aboriginal Health Access Centres, and Withdrawal Management Programs. ▪ Created a system for naloxone inventory management/distribution of naloxone to eligible community partners ▪ Memorandum of Understanding ▪ Sample policy/procedures, creation of training modules, and documentation tools. ▪ provided training sessions to eligible organizations • Communication campaign stressing the importance of calling 911 and that an overdose is a medical emergency

		<u>Activities – Treatment</u>
		• Education and training for ER staff to dispense naloxone (Perth/Smith Falls Hospital)
		• Education and training for Upper Canada/Catholic School Boards on responding to an opioid overdose (Naloxone in all First Aid Kits)
		• Education to Fire Departments/Police on opioids misuse/illicit fentanyl https://news.ontario.ca/mohltc/en/2017/12/ontario-expanding-opioid-response-as-crisis-grows.html
		    o Training for 2 Fire departments/Police as they purchased own Naloxone to use for first aid as well as in the situation of first responder in the community.
		• December 2017 the expansion program was announced to include Police and Fire as responders to opioid overdoses (Expansion Program). HU initiated below activities to ensure ready to respond when MOHLTC announced go live date in 2018.
		    o Prepare presentation to Municipalities on opioid misuse/illicit fentanyl
		    o Creating a system for naloxone inventory management/ distribution
		    o Memorandum of Understanding
		    o sample policy/procedures,
		    o training modules, and
		    o documentation tools organized
		
		<u>Activities – Enforcement</u>
		• Establish a communication protocol to contribute to ongoing surveillance/monitoring of illicit opioids in the community

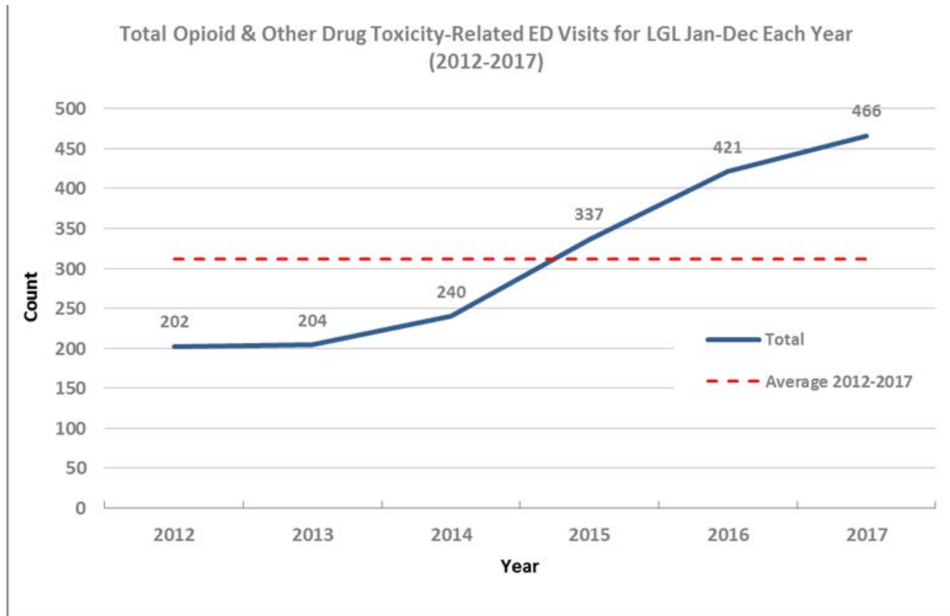
b. What is the best-available evidence that exists to support various courses of action?		

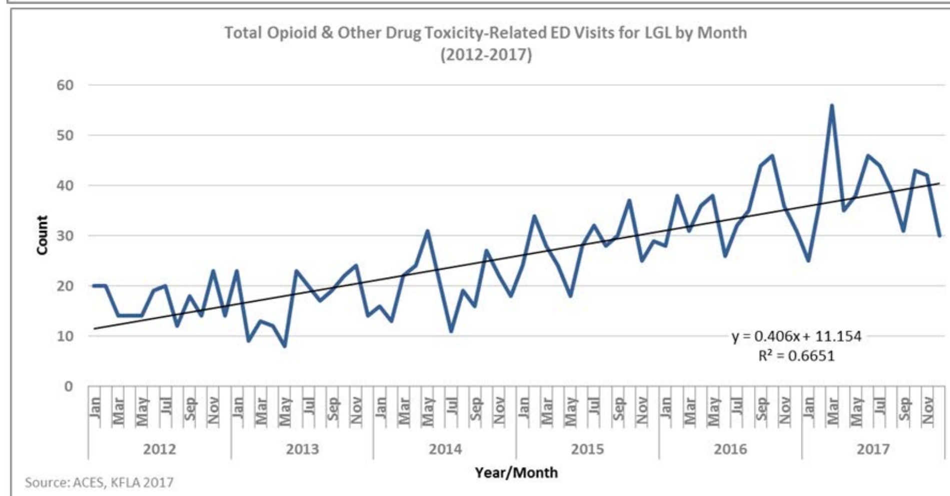
Situation 3: Potential for Overdose Cluster

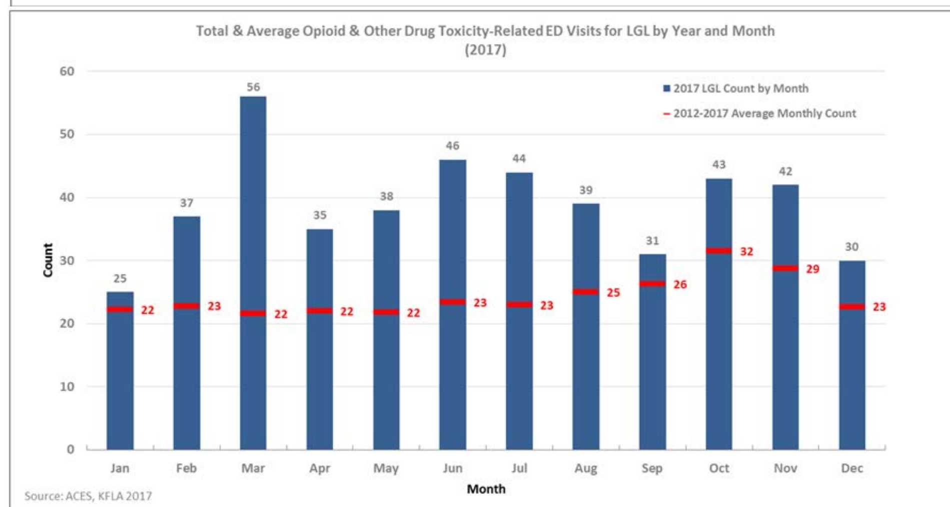
Situational Assessment Questions / Sub-Questions	Examples	Leeds, Grenville and Lanark – Situational Assessment
3. What possible actions can you take to address the situation?		**Situation 3: Potential for Overdose Cluster**
a. What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community? What evaluation data are available for these activities?	•Prevention •Treatment •Harm reduction •Education •Surveillance / research •Enforcement	• Adapted a Policy and Procedure for Firefighters Response to Suspected/Confirmed Opioid Overdose • Opioid Overdose Cluster Plan was developed **Activities – Harm Reduction** • Create a protocol for response to mass casualty that includes all multi-sectoral partners involved in attempt to decrease mobility and mortality focus on communication between agencies. • Fire services able to respond at scene of overdose and administer naloxone Ministry and Health and Long Term Care – Provide naloxone to all fire and police services in Ontario https://news.ontario.ca/mohltc/en/2017/12/ontario-expanding-opioid-response-as-crisis-grows.html **Activities – Treatment** • Create a protocol for response to mass casualty that includes all multi-sectoral partners involved in attempt to decrease mobility and mortality – focus on communication between agencies • Critical incident debriefing post mass casualty event or other significant event related to illicit opioid response • Create a protocol for response to mass casualty that includes all multi-sectoral partners involved in attempt to decrease mobility and mortality – focus on communication between agencies • Health and Safety issues identified and a plan to prevent and mitigate injury to the first responder • Media/communication response plan • Advocate for first responders (police and fire) to be trained in administering naloxone at the scene of an overdose **Activities – Enforcement** • Police able to respond at scene of overdose and administer naloxone Ministry and Health and Long Term Care – Provide naloxone to all fire and police in Ontario

		https://news.ontario.ca/mohltc/en/2017/12/ontario-expanding-opioid-response-as-crisis-grows.html
b. What is the best-available evidence that exists to support various courses of action?		Best Practice Guidelines- Harm Reduction http://www.catie.ca/sites/default/files/bestpractice-harmreduction-part2.pdf http://www.catie.ca/sites/default/files/BestPracticeRecommendations_HarmReductionProgramsCanada_Part1_August_15_2013.pdf Public Health Ontario data https://www.publichealthontario.ca/en/dataandanalytics/pages/opioid.aspx

Appendix A – Aces data for LGL December 2017 Data







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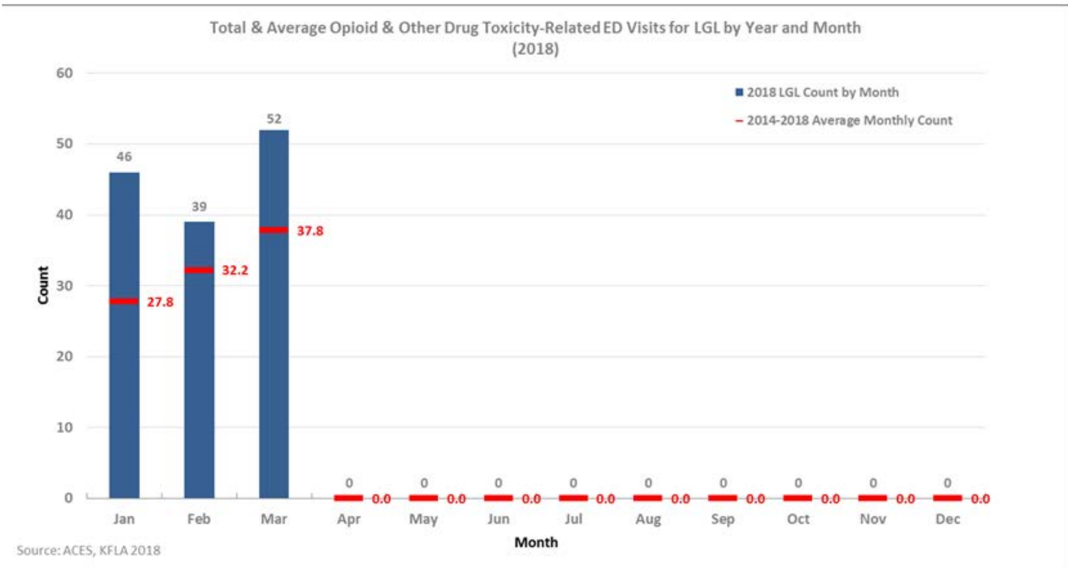
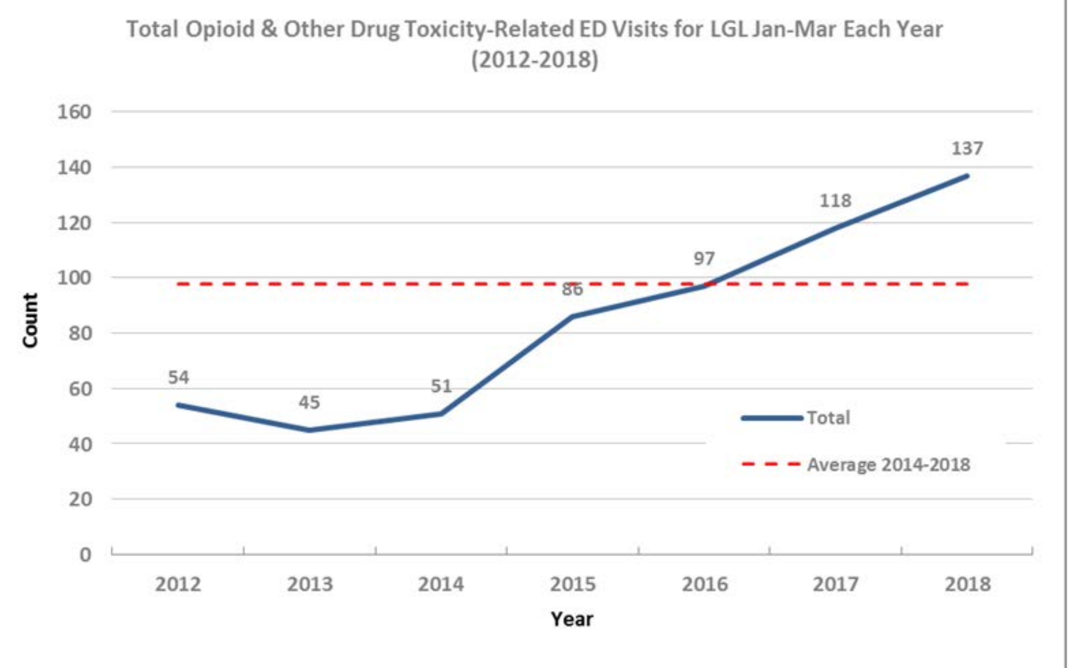
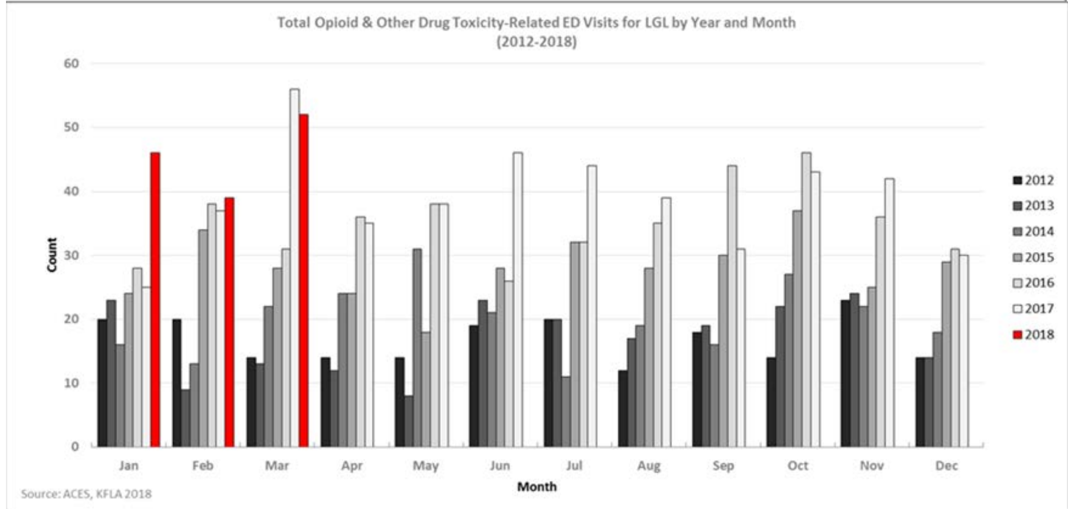
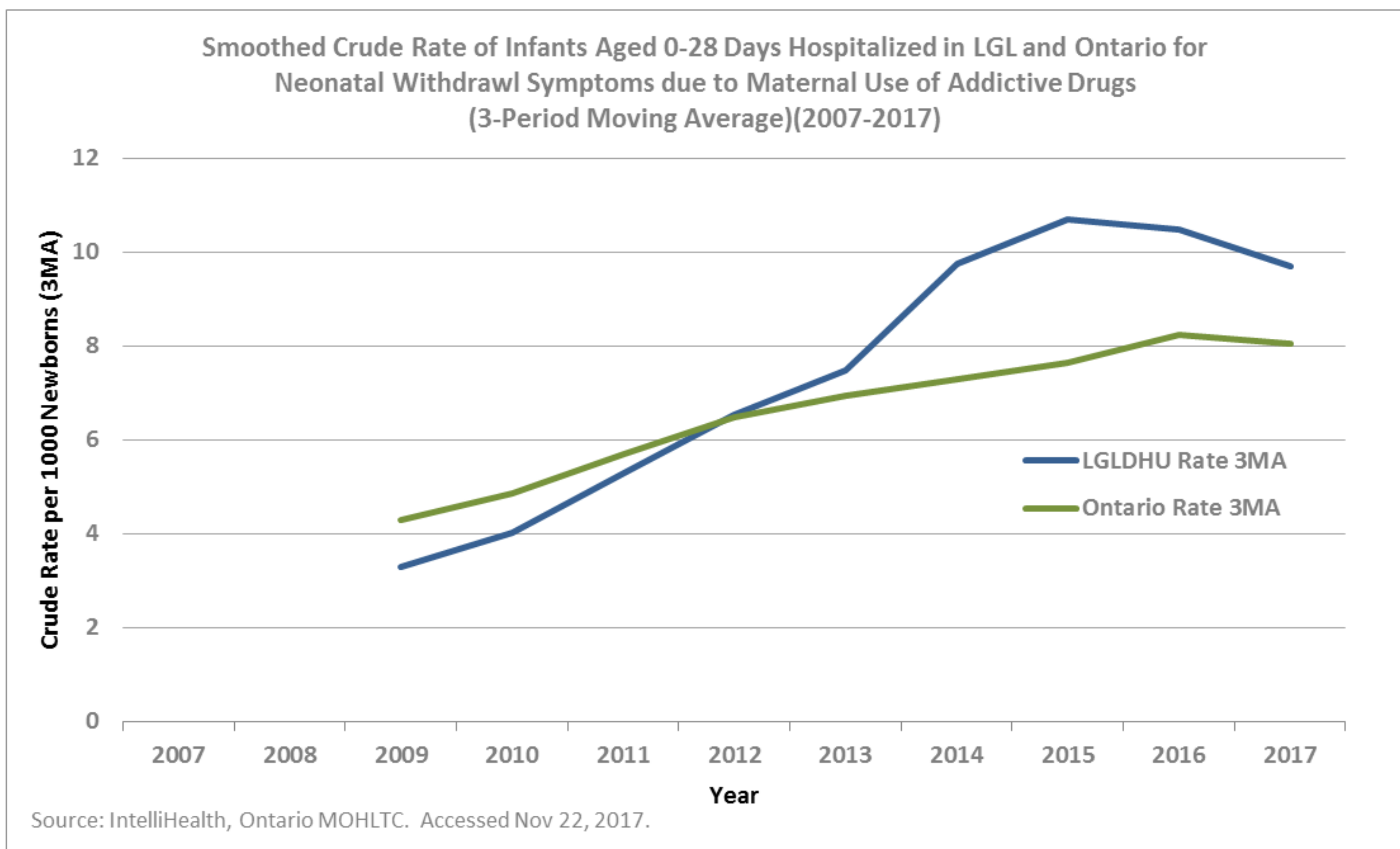


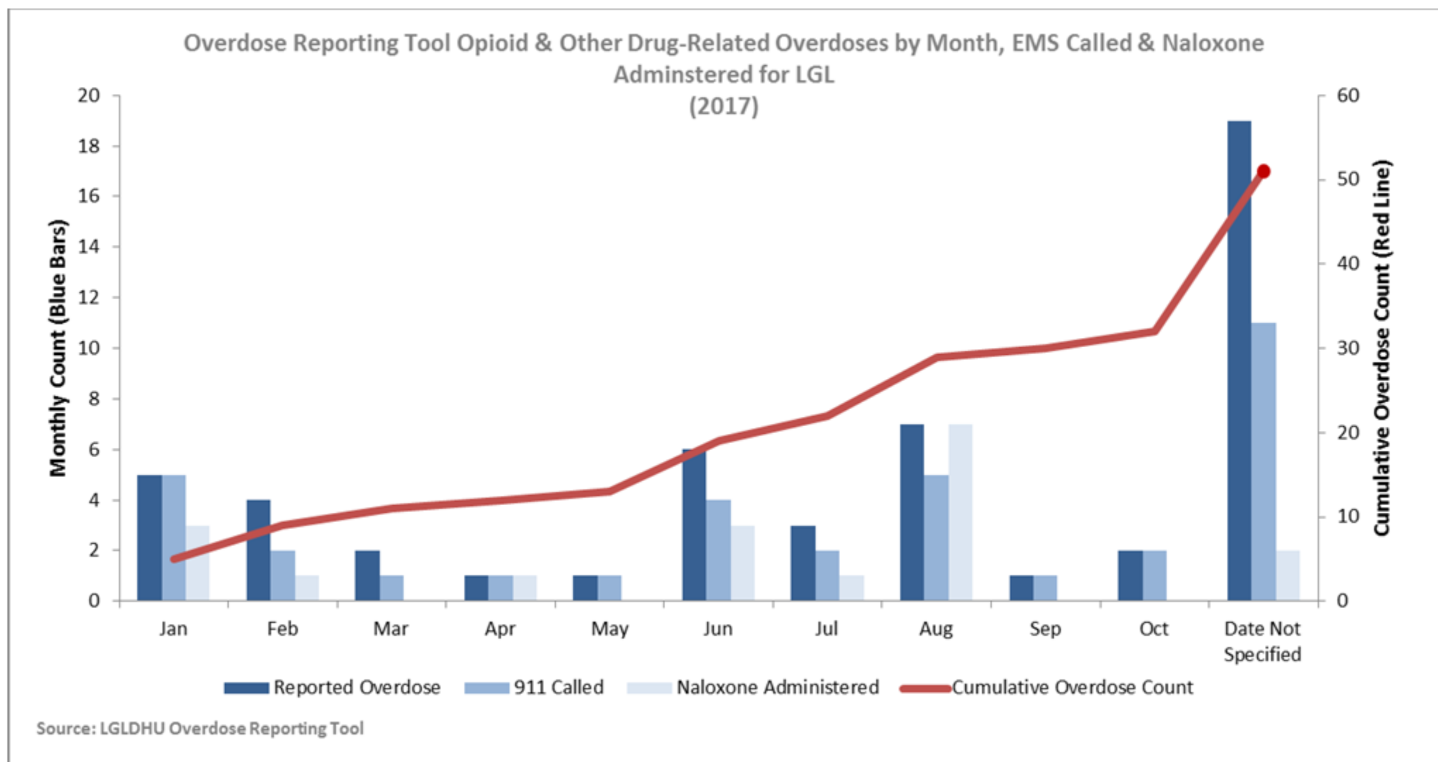




Appendix B – Neonatal Abstinence Syndrome Data LGL



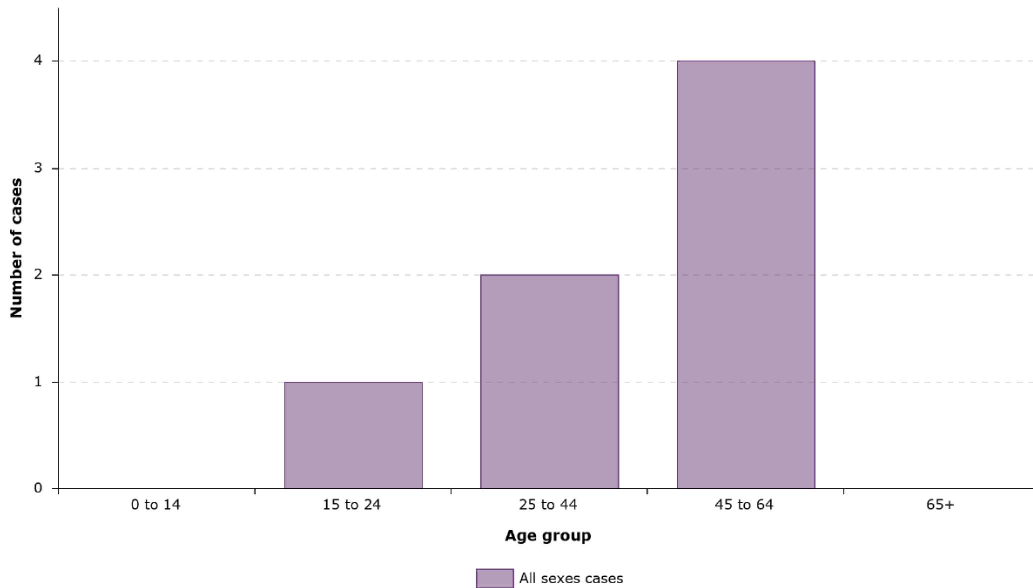
Appendix C – Overdose Reporting Tool 2017 LGL



Appendix D – PHO Data Opioid-related morbidity and mortality in LGL

Saved from:
http://www.publichealthontario.ca/en/DataAndAnalytics/Pages/Opioid.aspx#/ageSex

Cases of opioid-related deaths by age group,
Leeds, Grenville & Lanark District Health Unit, 2016



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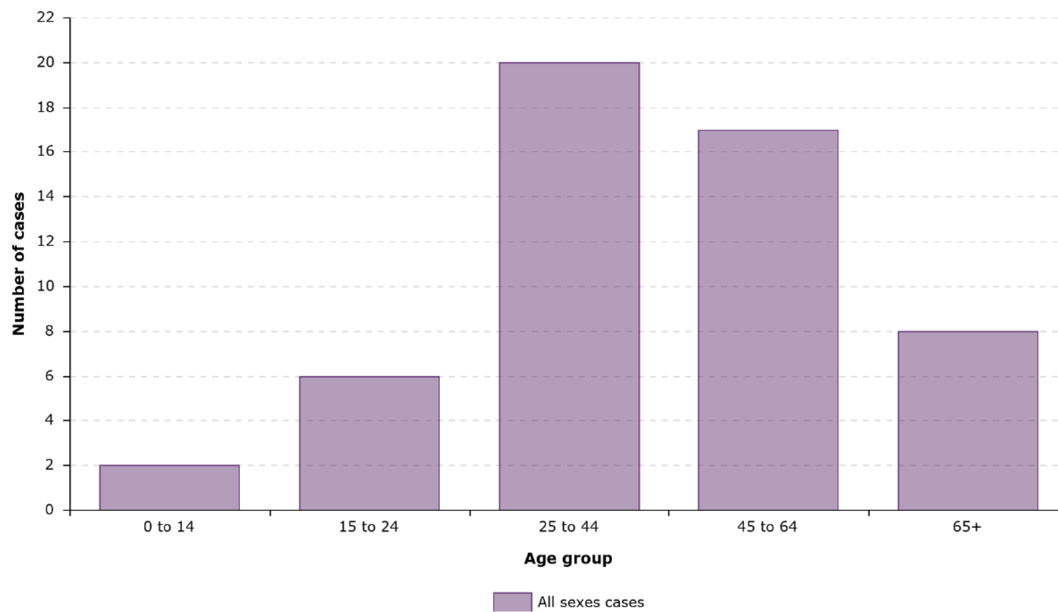
Cases of opioid-related ED visits by age group,
Leeds, Grenville & Lanark District Health Unit, 2016



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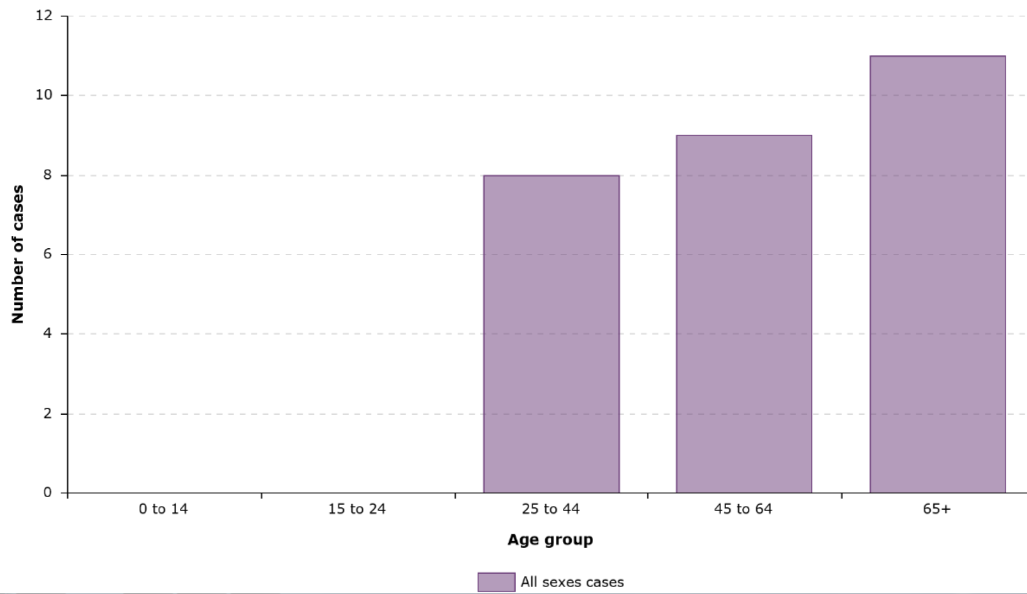
Cases of opioid-related hospitalizations by age group, Leeds, Grenville & Lanark District Health Unit, 2016



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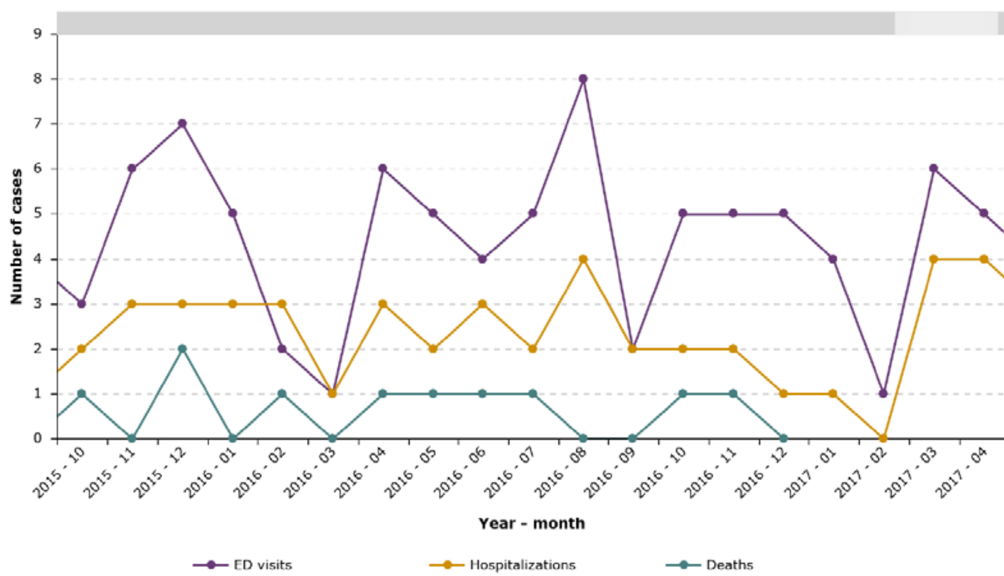
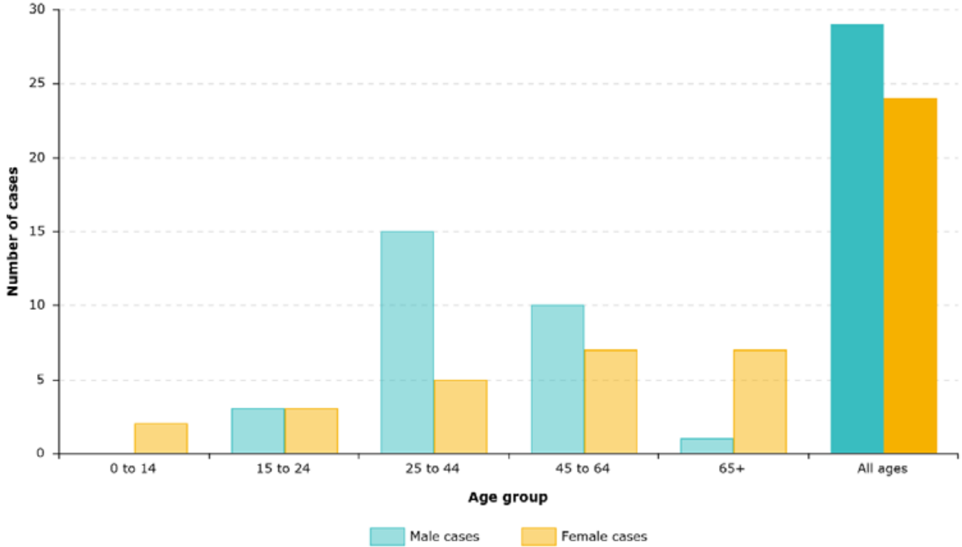
Cases of opioid-related morbidity and mortality, Leeds, Grenville & Lanark District Health Unit, 2003 - 01 – 2017 - 06



Appendix E – PHO Data Male and Female Opioid Related Death, ED visit and hospitalization

Saved from:
http://www.publichealthontario.ca/en/DataAndAnalytics/Pages/Opioid.aspx#/ageSex

Cases of opioid-related ED visits by age group,
Leeds, Grenville & Lanark District Health Unit, 2016



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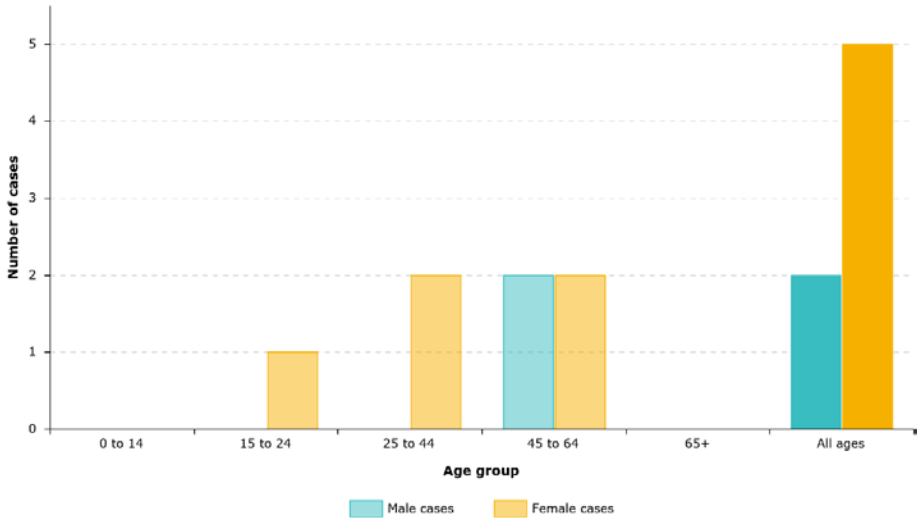
Cases of opioid-related deaths by age group,
Leeds, Grenville & Lanark District Health Unit, 2016



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