a short history of the opioid crisis

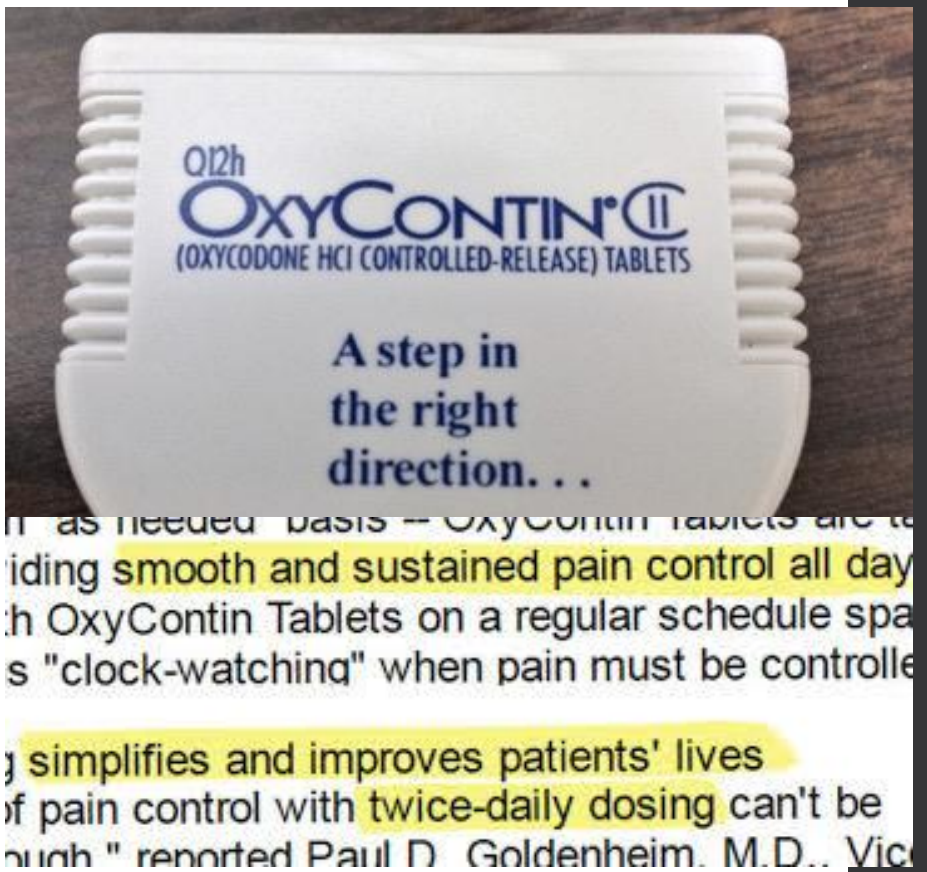
(And how this context can support our thinking on the crisis)

In the beginning…

- Opioids have been around for <u>a very long time</u>
  - Opium
  - Early nineteenth century: Morphine
  - 1874: Heroin invented
  - 1960s: Fentanyl developed

A shift in perspective…

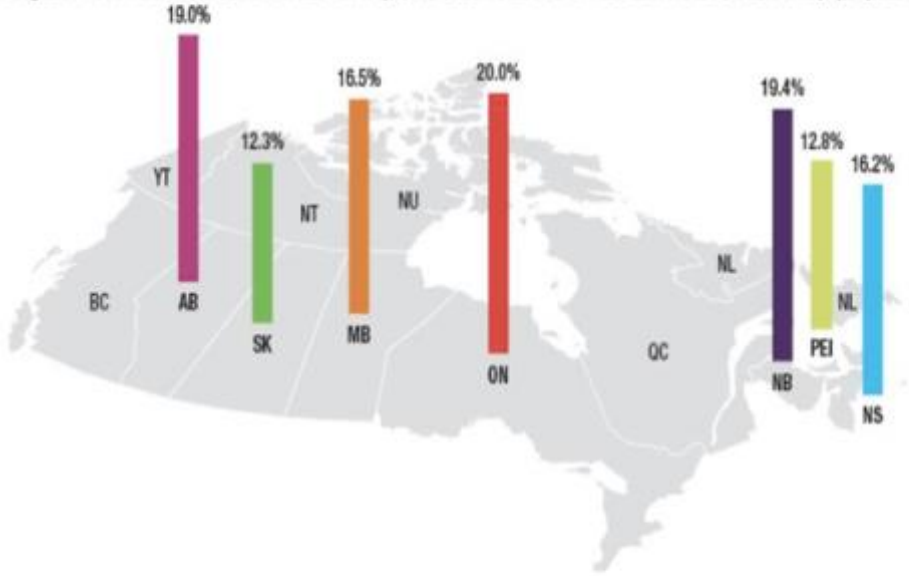
- Early 1990s: Promotion of the prescription of opiates by family physicians began
  - Pharmaceutical companies began marketing opioids as safe
  - American Pain Society Championed opioids as the "Fifth Vital Sign"
- GPs were often poorly trained in pain management and/or misinformed about how to safely prescribe these drugs
  - Often found conflicts of interest in physician education
- "Doctor shopping" practices began among patients
- Poor regulation and little monitoring by government of prescriptions



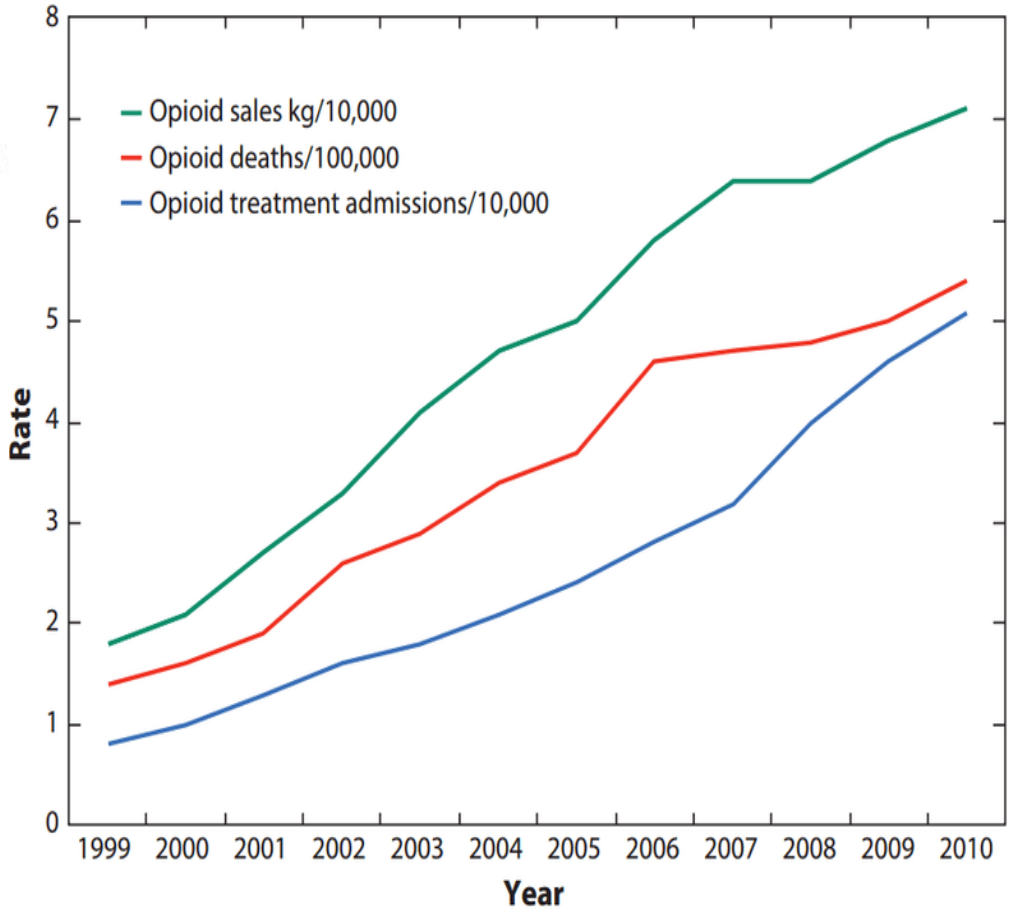
As use increases, so do related harms…

Opioid Use in Canada

Figure 1.1 Number and share of opioid claimants in the active beneficiary population, 2012/13



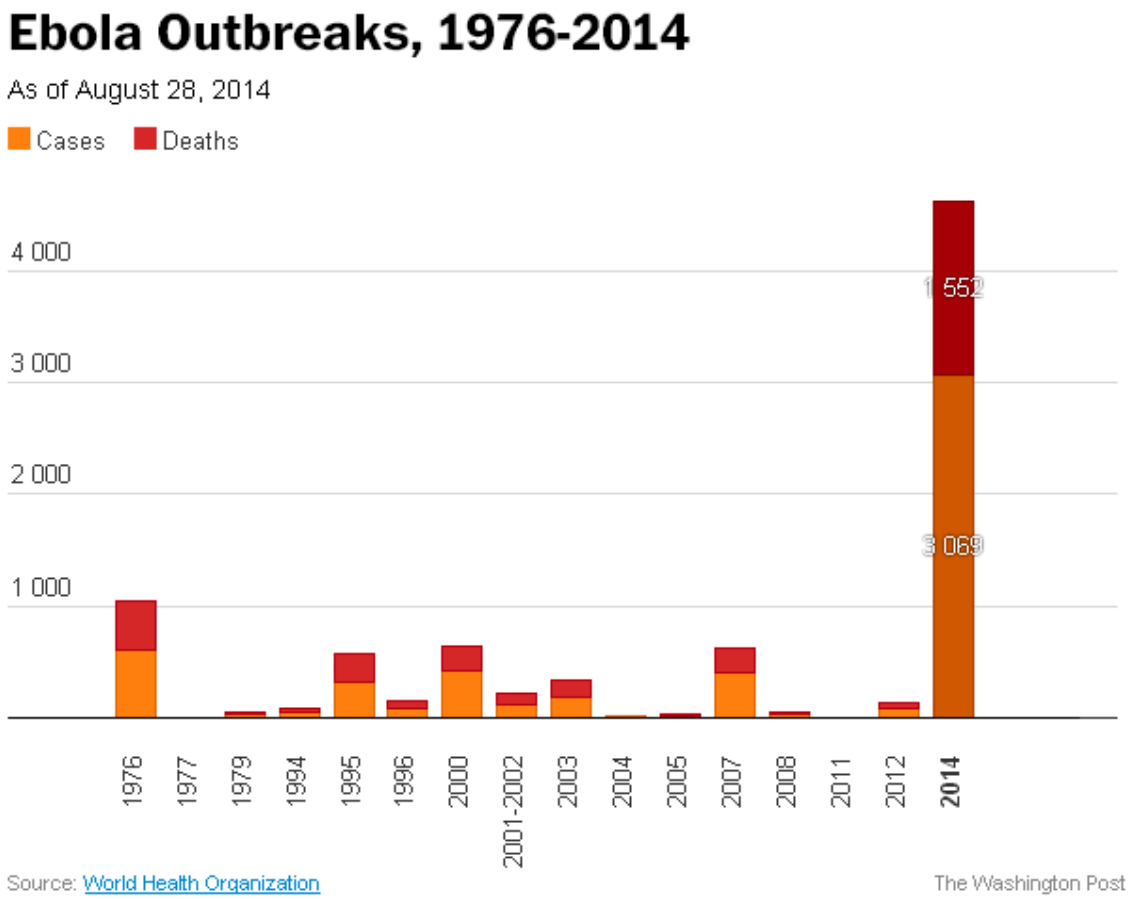
Utilization of Prescription Opioids in Canada's Public Drug Plans, 2006/07 to 2012/13April 2014. Government of Canada.
Available: http://www.pmprb-cepmb.gc.ca/view.asp?ccid=1033



U.S. data

Question: What made the conditions so favourable for an opioid epidemic?

- Outbreaks happen all the time
- For an epidemic to occur, the conditions have to be favourable
- Drug epidemics are similar, but more complex

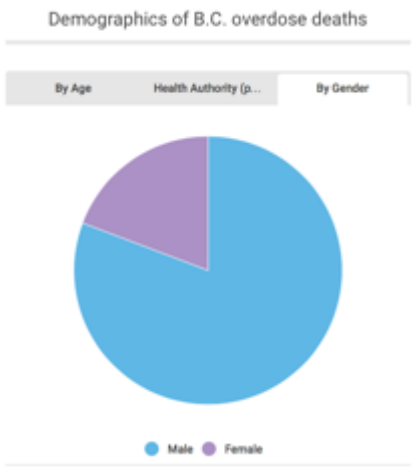


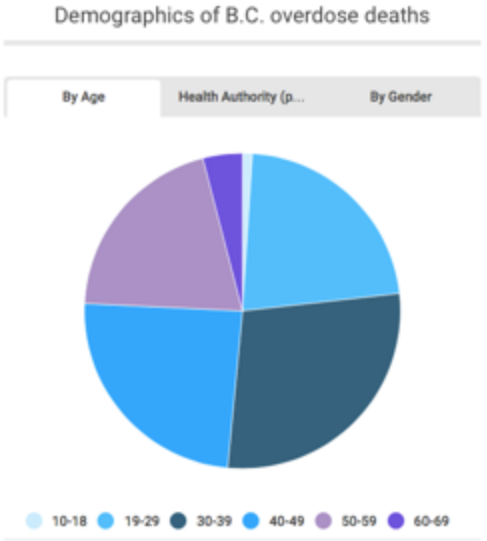
What do the trends tell us? (BC data)

BC Data by Gender/Age:

Illicit Drug Overdose Deaths by Gender, 2007-2016 [2]										
Gender	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Female	47	49	55	49	81	75	78	86	99	150
Male	155	134	146	162	211	194	252	280	411	605
Total	202	183	201	211	292	269	330	366	510	755

Age-Specific Illicit Drug Overdose Death Rates per 100,000, 2007-2016 [2,5]										
Age Group	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
10-18	1.0	1.3	0.4	0.9	0.9	1.1	1.3	0.7	1.1	2.5
19-29	5.2	5.5	6.9	5.9	10.9	8.9	13.7	11.9	16.5	26.7
30-39	9.1	8.2	8.6	8.3	12.5	10.2	12.7	16.4	21.3	37.0
40-49	10.1	6.1	8.3	9.7	11.3	9.9	11.2	13.3	19.4	31.0
50-59	5.8	6.8	5.1	6.8	8.0	8.2	8.5	10.0	15.2	23.1
60-69	1.0	1.8	2.6	1.5	2.0	3.7	3.9	4.3	4.5	5.1
70-79	0.4	0.0	0.0	0.0	0.0	0.3	0.0	0.0	0.3	0.9
Total	4.7	4.2	4.6	4.7	6.5	5.9	7.2	7.9	10.9	17.4





Males more than females

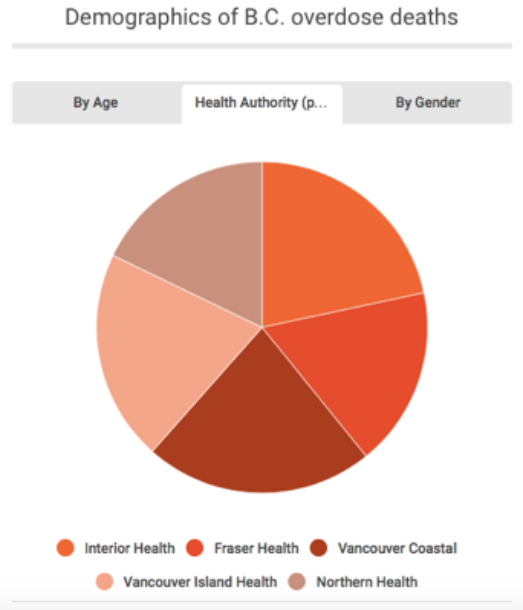
Males:Females 3:1 in 2007, now 4:1

Increasingly younger

In 2007, those most affected were aged 30-49, with highest rates in in the 40-49 category. In 2016, the numbers have shifted with highest rates in the 30-39 category and equal rates in the 19-29 category as the 40-49 category

What do the trends tell us? (BC data)

Illicit Drug Overdose Death Rates by Health Services Delivery Area per 100,000, 2007-2016[2,4-6]										
HSDA	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
East Kootenay	2.7	2.6	1.3	0.0	1.3	2.6	5.3	5.2	2.6	9.9
Kootenay Boundary	5.2	0.0	2.6	3.9	5.1	5.2	2.6	3.9	7.8	8.5
Okanagan	3.9	2.6	4.3	5.2	8.1	4.6	9.2	7.6	11.6	19.4
Thompson Cariboo	7.5	5.1	7.8	7.4	2.3	4.1	6.9	5.9	5.9	23.7
Fraser East	3.3	5.1	3.2	7.8	10.9	7.0	6.6	5.5	13.9	17.5
Fraser North	3.3	3.8	3.8	4.2	4.0	4.8	5.5	7.9	11.3	13.7
Fraser South	4.3	4.2	3.7	5.3	8.0	7.2	6.6	7.6	11.7	17.3
Richmond	0.0	0.5	1.6	2.0	2.0	0.5	1.5	1.5	2.4	5.2
Vancouver	9.5	6.1	9.6	6.6	10.7	10.1	12.2	15.0	20.1	26.5
North Shore/Coast Garibaldi	1.9	3.0	2.2	2.2	2.9	2.2	4.3	5.3	5.3	7.3
South Vancouver Island	5.9	8.6	4.1	3.5	4.6	5.4	7.0	6.2	5.8	19.8
Central Vancouver Island	3.2	2.3	5.0	2.3	6.5	7.6	9.1	9.4	11.2	19.8
North Vancouver Island	5.2	5.1	4.2	3.4	8.3	3.4	6.7	5.8	6.6	18.8
Northwest	2.7	2.7	0.0	4.1	1.4	0.0	8.2	2.7	8.3	12.1
Northern Interior	5.0	2.1	3.6	5.0	5.6	8.5	5.7	7.8	10.8	11.9
Northeast	3.1	1.5	1.5	4.5	8.9	8.8	7.2	11.3	5.7	23.3
Total	4.7	4.2	4.6	4.7	6.5	5.9	7.2	7.9	10.9	17.4



Disproportionately rural

Over the last 10 years, the risk of overdose outside of major municipal centres in BC has increased by 20%.

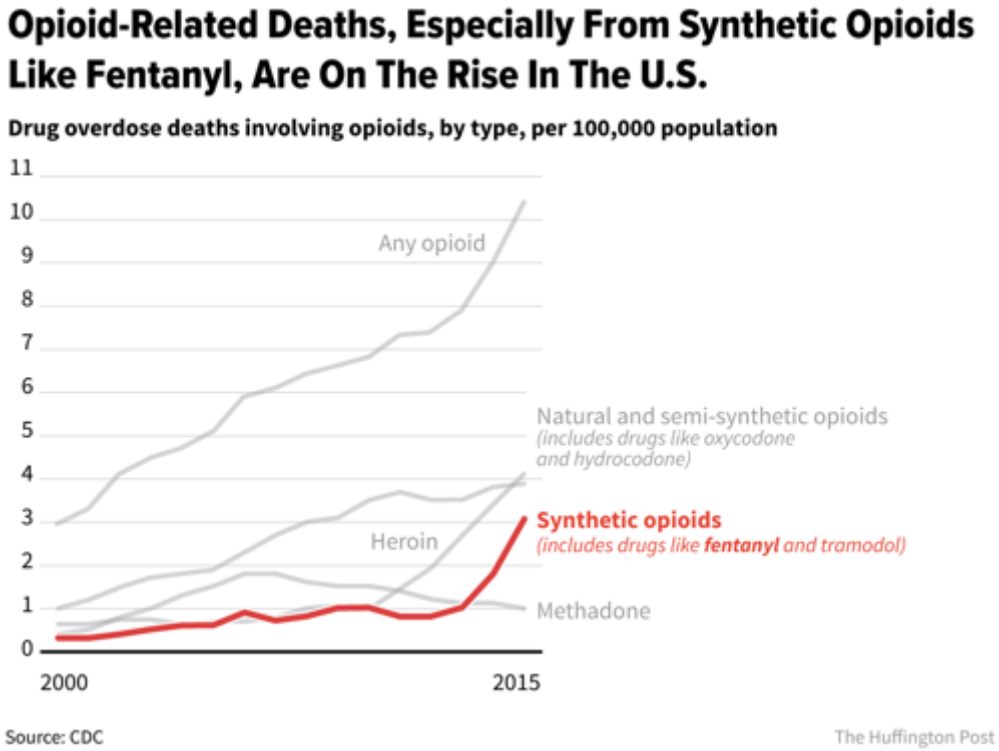
What's been the tipping point?

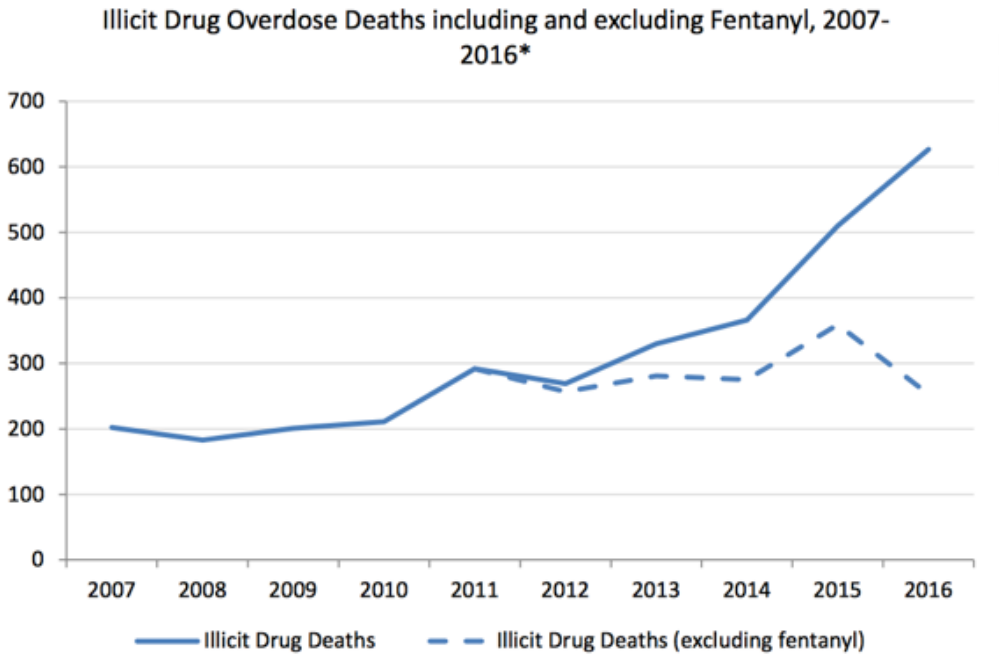
Thompson Rivers University vice president killed by accidental drug overdose

Two main factors: Regulatory efforts and a dried up supply of heroin

- Noticing the trends in opioid use, governments realized they needed to step in
- Actions taken:
  - Increased policing efforts
  - Restriction of/Tamper proofing of popular opioids
  - Retraining/educating doctors in prescribing practices
  - Regulation of pharmaceutical marketing practices
  - Introduction of computer monitoring systems
  - Targeting of doctor shopping practices
- Supplies of heroin also began to falter – while access to synthetic opioids from China became more appealing for drug lords (not mutually exclusive)

The result? Opioid prescriptions decline, but deaths from synthetic opioids increase dramatically





BC Coroner's Report, 2016

What can and should we do?

The role of dialogue in supporting and rebuilding community

Adopt a more substantive framework?

- **Doing health promotion**

  increase individual and community health capacity, opportunity and action to take increased control of their wellbeing

- **Pursuing culture change**

  help people together to be more shapers of than just shaped by factors of influence around them

- **Engaging in dialogue**

  involve people in conversations geared to better understanding

Health promotion: what distinguishes it?

- **Salutogenic thrust** – holistic wellness

  versus pathogenic frame – absence of illness/injury

- Attention primarily on **collective wellbeing**, not just individual

- Aim to improve **environments**, conditions that impact on wellbeing – socio-ecological approach

- Intersectoral, **multidisciplinary** endeavor, combined strategies – not just the responsibility of healthcare/services personnel

- **Empowering thrust**, affirming agency, building connectedness, enhancing literacy (skill)

Culture change: what does it involve?

Helping people (fellow campus members) collectively to be more

- **reflective** – about common basic *assumptions, beliefs*
- constructively **critical** – about shared *values*
- **intentional** – about popular social *practices*
- consciously **collaborative** – in choosing and pursuing *goals and means*

Dialogue: what ***is*** it?

A way of being with others and **a manner of communication**

- Bidirectional conversation in which people really *listen*
- Interchange in which participants are *open* to gain perspective
- *Exploration* which suspends judgments, poses open questions, examines assumptions
- Exercise which is *inclusive of and receptive to others* as fellow citizen learners, peers, equals
- A way of relating that is very comparable to a *motivational interviewing* approach in conversing with another individual

Dialogue: what is it ***not?***

NOT: a method, technique, typical tack in health communication

- Discussing, debating, defending, directing
- Warning, informing/instructing, persuading, proving
- Social marketing, telling, advising, advocating, prescribing
- Reaching agreement/consensus
- Problem solving

Dialogue: how do we engage people in it?

No blueprint, formula, rules, recipe, but a principled approach

- Reach out, *build rapport*, identify misunderstandings & divides
- Plan suitable settings, invite, recruit, capitalize on diversity
- Welcome, affirm interdependence, encourage reciprocity, *elicit*
- *Empathize* (strive to identify with others' experience, vantage point)
- Listen attentively, reflectively; learn intentionally, appreciatively
- Thus: *model it* from the start in interaction with those you are seeking to engage in it

Opioid-related benefits of dialogue?

- Enhanced **understanding, appreciation** among those who use and those who don't
- Enhanced **community connectedness, inclusion and integration**, which will itself work against a growing incidence of harmful opioid use
- Enhanced **readiness to support, collaborate** on opioid-related concerns
- Enhanced **readiness to explore, implement** innovative responses

Resources

Information about Fentanyl

Toward the Heart: General information about fentanyl in BC, including FAQs, tips for reducing the risk of overdose and information about where to get help.

http://towardtheheart.com/fentanyl/

HeretoHelp's Safer Use Injecting: A harm reduction pamphlet

http://www.heretohelp.bc.ca/sites/default/files/safer-injecting-heroin-crack-and-crystal-meth.pdf

Naloxone Kits/Information

B.C. Pharmacists: Includes education, handouts and training information relevant to the use of naloxone.

http://www.bcpharmacists.org/naloxone

Toward the Heart: Information about BC's take-home naloxone kits and information about training to administer naloxone.

http://towardtheheart.com/naloxone/

Resources

Health Promotion Resources

HeretoHelp's Understanding Substance Use: a health promotion perspective

http://www.heretohelp.bc.ca/factsheet/understanding-substance-use-a-health-promotion-perspective

HeretoHelp's Helping People who Use Substances: a health promotion perspective

http://www.heretohelp.bc.ca/factsheet/helping-people-who-use-substances-a-health-promotion-perspective

Selkirk College's Dinner Basket Conversations: A promising practice tool from Selkirk College on the application of community dialogue on substance use in the campus setting.

https://healthycampuses.ca/resource/promising-practice-selkirks-hosting-a-dinner-basket-conversation/

Reducing Harms: Recognizing and Responding to Opioid Overdoses in Your Organization

Jean Hopkins, Policy Analyst, Canadian Mental Health Association, Ontario Division
jhopkins@Ontario.cmha.ca

Canadian Mental Health Association
Ontario

What is Harm Reduction?

An evidence-based, client-centred approach that seeks to reduce the health and social harms associated with substance use, without necessarily requiring people who use substances from abstaining or stopping.

- **Pragmatism***:* Harm reduction recognizes that substance use is inevitable in a society and that it is necessary to take a public health-oriented response to minimize potential harms.
- **Humane Values***:* Individual choice is considered, and judgement is not placed on the substance user.
- **Focus on Harms***:* An individual's substance use is secondary to the potential harms that may result in that use.

Opioids in Ontario

80 per cent of people entering residential treatment for opioids were first exposed through a prescription.

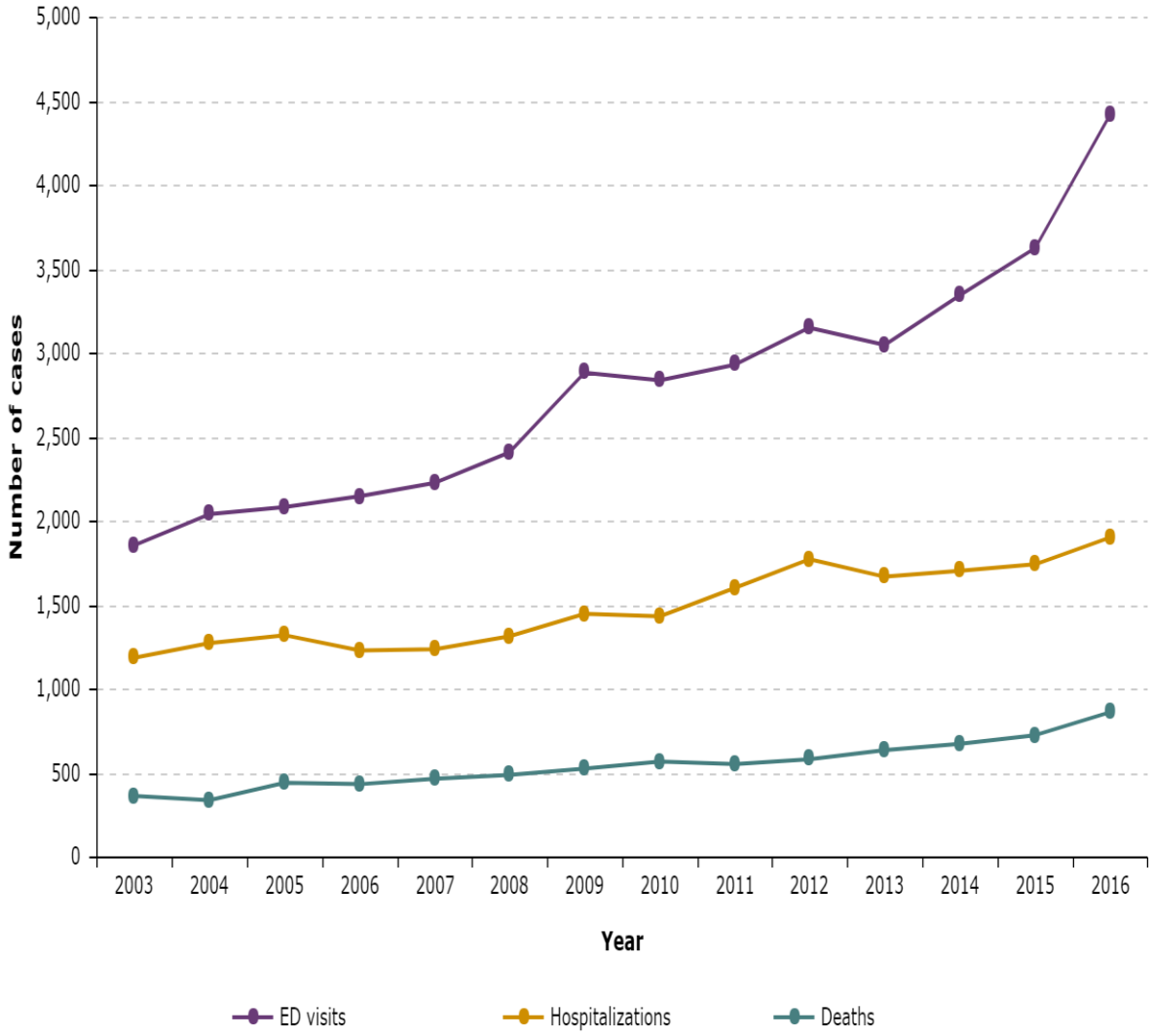
Among young adults ages 25 to 34, **1 of every 8 deaths** is due to Opioids.

Fentanyl is the leading cause of opioid deaths in Ontario. Hydromorphone is second.

Most recent data from 2016 – at least **865 deaths** related to opioids

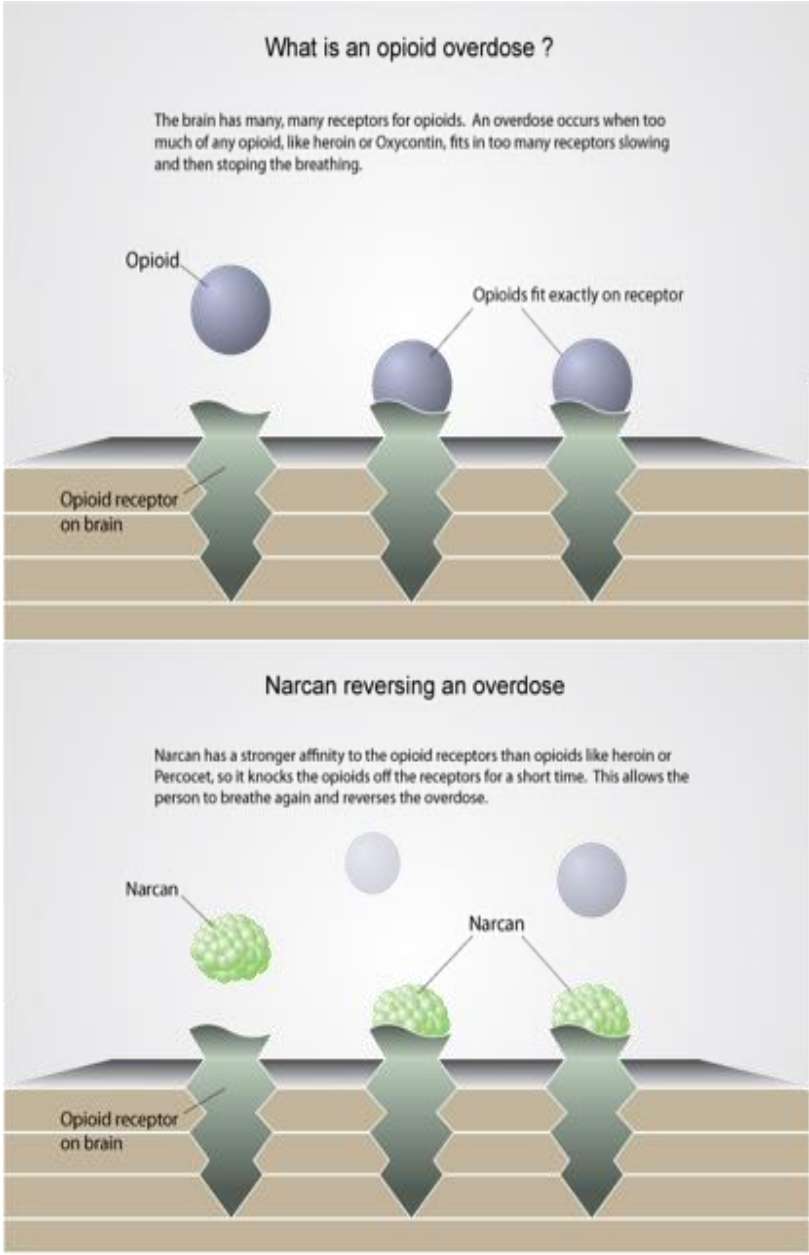
Currently an overdose death due to opioids **occurs every 10 hours in Ontario.**

Cases of opioid-related morbidity and mortality, Ontario, 2003 – 2016



Naloxone (Narcan™)

- Injectable or intranasal medication
- Reverses the effects of opioids (opioid antagonist)
- No prescription needed, and free of charge
- Only last for a short period of time
- It will not have an effect on other substances in the body
- No harms if administered to someone who is not experiencing an overdose



Naloxone (Narcan™)

Intramuscular Naloxone

Intranasal Naloxone

Naloxone Availability

https://www.ontario.ca/page/where-get-free-naloxone-kit

Ontario Naloxone Program (OPS) (No health card needed)

Ontario's needle syringe programs and hepatitis C programs provide kits containing Intranasal naloxone (4mg/0.1ml) to:

- Clients of needle syringe and hepatitis C programs
- Friends and family of clients
- Individuals newly released from a correctional facility

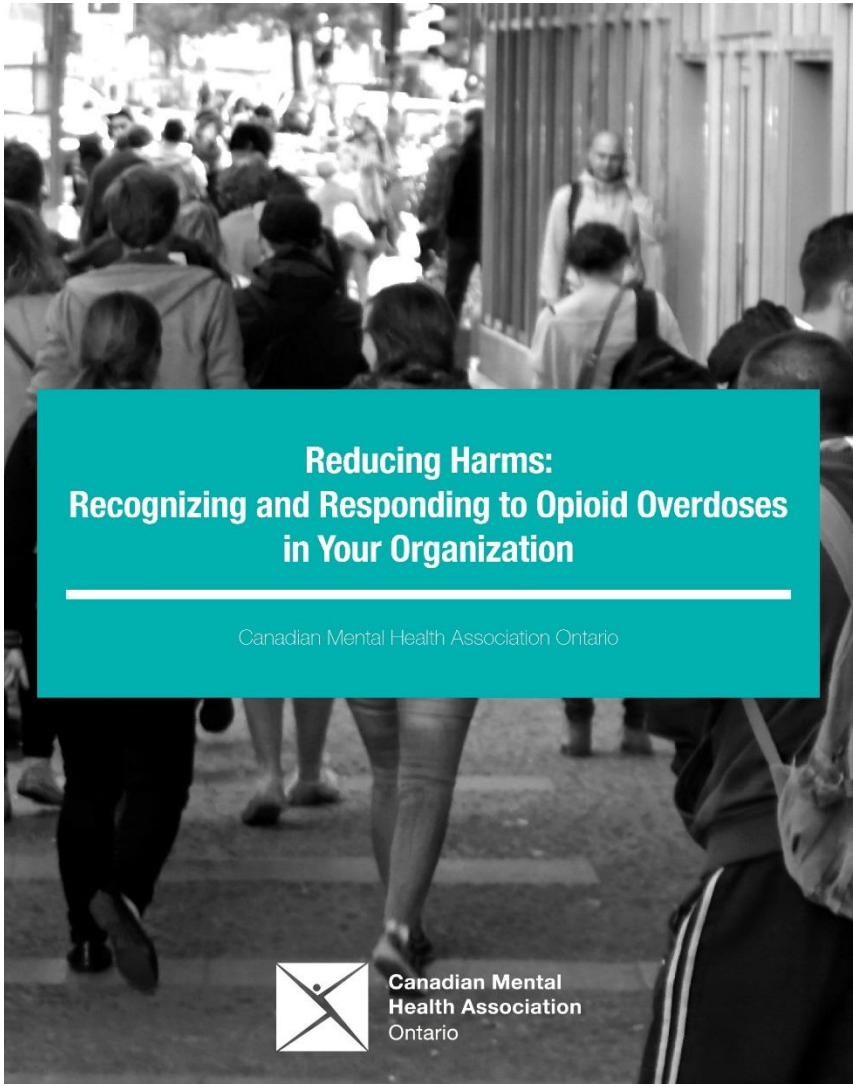
Ontario Naloxone Pharmacy Program (OPPS)
(Health card needed)

Participating pharmacies distribute intramuscular naloxone (0.4mg/1ml) kits to:

- Individuals currently using opioids
- Past opioid users who are at risk of returning to opioid use
- A family member, friend or other person in a position to assist a person at risk of overdose from opioids

Purpose of Our Document

- The '**Reducing Harms: Recognizing and Responding to Opioid Overdoses in Your Organization'** will:
- Provide current, accurate and relevant information about opioids and naloxone in Ontario
- Assist organizations to develop and implement an overdose prevention protocol
- Provide infographics on administering naloxone and templates for policy development
- Encourage naloxone to be a part of any first aid protocol



Topics Covered in Our Document

- **Opioids and Naloxone in Ontario**
  - Understanding harm reduction
  - Who is at risk
- **Administering Naloxone**
  - Signs and symptoms of an overdose
  - Intramuscular, Intranasal and aftercare
- **Setting Up Naloxone Administration as a First-Aid Response in Your Organization**
  - Developing a protocol
  - Training options
  - Opioid risks in the workplace
  - Debriefing and distress prevention
- **Additional Considerations**
  - Incorporating equity into your overdose protocol
  - Monitoring and evaluation
  - Good Samaritan Legislation
  - Developing a communication strategy
- **Templates & Infographics**

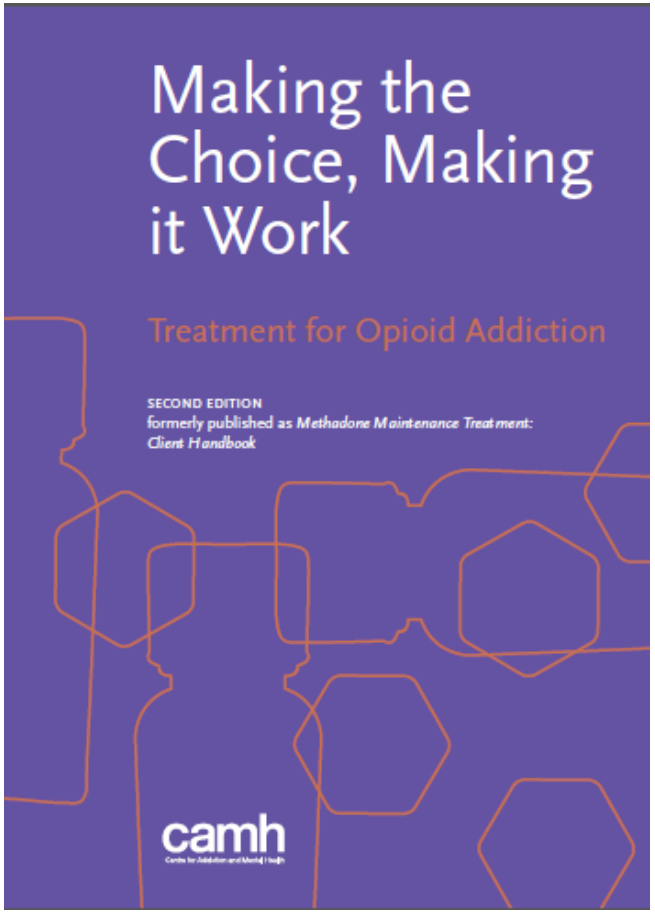
ADMINISTERING INTRAMUSCULAR NALOXONE

1. 
   Shake shoulders and shout name
2. 
   Call 911 if unresponsive
3. 
   Inject 1 vial or ampoule of naloxone into their upper arm or upper leg
4. 
   Perform first aid; give chest compressions
5. 
   If breathing has not improved after two to three minutes, perform step 3 and 4 again
6. 
   If breathing has resumed, place in recovery position

ADMINISTERING INTRANASAL NALOXONE

1. 
   Shake shoulders and shout name
2. 
   Call 911 if unresponsive
3. 
   Lie person on their back. Insert nozzle tip into one nostril. Firmly press plunger
4. 
   Perform first aid; give chest compressions
5. 
   If breathing has not improved after two to three minutes, perform step 3 and 4 again
6. 
   If breathing has resumed, place in recovery position

Making the Choice, Making it Work



CAMH's most popular publication, updated in 2016 to reflect:

- Changing landscape of opioids
- Changing demographics of people seeking opioid treatment
- Expansion of treatment options available beyond methadone
- Available in English/French, online, brochure

Resource Topics

- FAQ about opioid agonist therapy
- Information to help people choose between opioid agonist therapy and other treatment options
- A methadone and buprenorphine comparison chart
- Information on side-effects, interactions with other drugs and on avoiding and responding to overdose

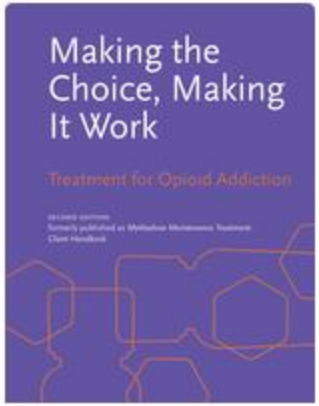
Resource Topics

- Information on counselling and its benefits
- Role of opioid agonist therapy in sexuality, pregnancy and the family
- Checklist to assess tapering readiness
- Lists of important contacts and websites for more information

What this Resource Does

- Provides current, accessible, accurate and relevant information regarding evidence-based opioid treatment options
- Helps people understand expectations, benefits, and restrictions of treatment options
- Provides a book that people can share with family and friends

How to Access



Making the Choice, Making It Work

$4.25

Details

[CAMH Online Store]

Making the Choice, Making It Work

TREATMENT FOR OPIOID ADDICTION

Second edition—formerly published as Methadone Maintenance Treatment: Client Handbook

[Read it Online]

Need More Information?

Opioid Resource Hub at: orh@camh.ca

https://www.porticonetwork.ca/web/opioid-resource-hub

Or contact: tamar.meyer@camh.ca