The Role of WDGPH in the Prevention and Harm Reduction of Opioid Misuse

TO:	Chair and members of the Board of Health
MEETING DATE:	February 1, 2017
REPORT NO:	**BH.01.FEB0117.R06** Pages: 10
PREPARED BY:	Jennifer McCorriston, Manager, Healthy Communities and Public Policy and Amy Estill, Health Promotion Specialist, Healthy Communities and Public Policy
APPROVED BY:	Rita Sethi, Director, Community Health and Wellness
SUBMITTED BY:	*Original signed document on file* Dr. Nicola J. Mercer, MD, MBA, MPH, FRCPC Medical Officer of Health & CEO

Recommendations

It is recommended that the Board of Health:

1. **Receive this report for information.**

Key Points

- Ontario has the highest annual dispensing rate of high-dose opioids, when compared to other provinices.[1]
- Opioid overdose and death are at an all-time high. In 2014, over 700 people died in Ontario from opioid-related causes; a 266% increase since 2002.[2]
- The province has announced *A Strategy to Prevent Opioid Addiction and Overdose in Ontario*.[2] This comprehensive strategy includes: i) Modernizing Opioid Prescribing and Monitoring, ii) Improving the Treatment of Pain, and iii) Enhancing Addiction Supports and Harm Reduction.
- The Ontario Public Health Standards (OPHS, 2008) dictates that Public Health will reduce the frequency, severity and impact of substance misuse, and prevent or reduce the burden of blood-borne infections.[3] Wellington-Dufferin-Guelph Public Health (WDGPH) accomplishes these goals through surveillance, health communication, mobilizing community partners and advocacy for healthy public policy.

- WDGPH works collaboratively with community partners on a harm reduction strategy. In the community this includes: the needle exchange program, counselling and support at on-site locations or through community outreach, and distribution of naloxone kits and appropriate training.
- WDGPH is committed to examining current opioid use in the community and working with partners to identify existing programs/services and assessing where gaps may exist. The findings will be presented in an upcoming BOH report.

Discussion

Background

In the past 20 years, there has been a rise in opioid prescribing practices across North America.[4] There are many types of opioids, including the prescription painkillers oxycodone, fentanyl and morphine, and illegal street drugs such as heroin. Medically speaking, opioids are prescribed by a health-care provider to relieve pain. Nevertheless, when used inappropriately there is tremendous risk of adverse effects to the individual. For those that use recreational opioids or misuse prescription opioids, escalating use can result in dependence, addiction, overdose and in some cases, death.

The reason behind the rise of opioid prescriptions provincially, nationally and internationally remains unknown, however it may be rooted in multiple factors.[4] It has been proposed that prescribing practices of health-care providers have changed over the years due to limited effectiveness and toxicity of other painkillers.[4] The Federal Health Minister, Jane Philpott, has also suggested, that the pharmaceutical industry has put insistent pressure on health-care providers to use opioids to treat chronic pain.[5]

Whatever the reason, it is clear that there has been an increase in overdoses and deaths in recent years. According to the Ministry of Health and Long-Term Care, over 700 people died in Ontario from opioid-related causes in 2014; a 266% increase since 2002.[2] The misuse of opioids and the related health and social outcomes have a significant impact on families and within communities.

Current Local Data

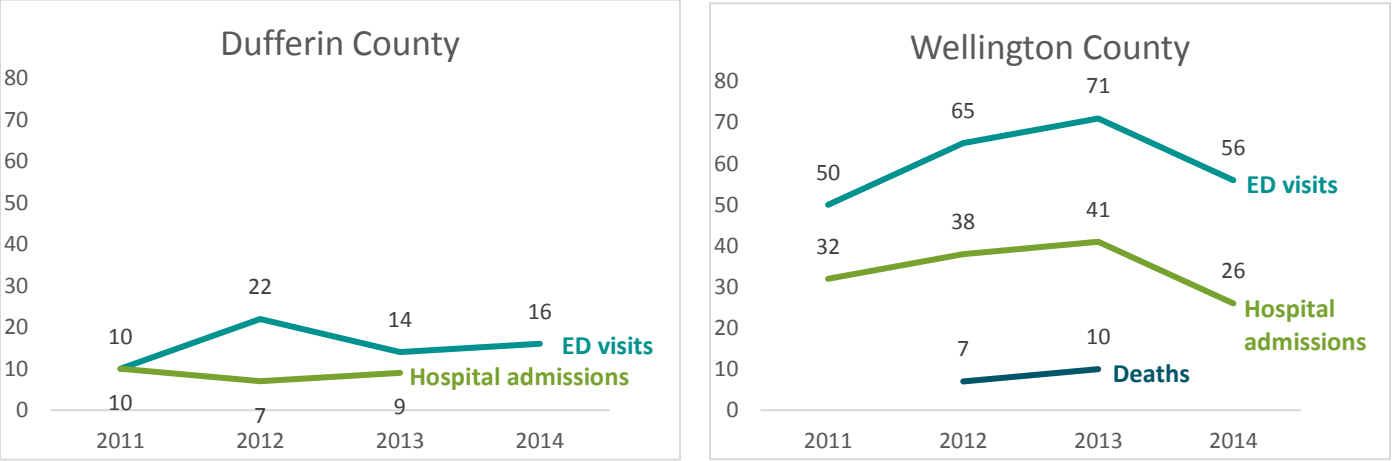
There is somewhat limited data available to paint a picture of opioid use and prescribing practices locally. However, there is some available local data when it comes to opioid-related harms and adverse effects (e.g. ER visits, hospitalizations and deaths).

The Ontario Drug Policy Research Network (ODPRN) released opioid data at a County level and ranked prescribing practices and harms across all Counties within Ontario.[6] The rate of opioid use among active Ontario Drug Benefit (ODB) beneficiaries in Wellington County (which included the City of Guelph) was 1,997 per 10,000 in 2015. The Wellington County rate was slightly below the provincial average and ranked 35 out of the 49 Counties (with 1 representing the highest rank). In Dufferin, the rate of opioid use among active Ontario Drug Benefit

beneficiaries in 2015 was 2,226 per 10,000. This was slightly above the provincial average and ranked 20 out of 49 Counties. Notwithstanding, this does not paint a picture of opioid use in the overall population as this data is only a reflection of the number of individuals that were dispensed an opioid through the ODB program (ODB beneficiaries may include seniors, individuals with a low socioeconomic status, individuals receiving disability etc.). Furthermore, past research has found that the rate of opioid prescriptions is higher among public drug beneficiaries than the general population.[1]

The ODPRN also produced data on opioid-related emergency department (ED) visits, hospitalizations and deaths, which are available in Figure 1.

Figure 1: Opioid-related Emergency Department visits, hospital admissions, and deaths from 2011-2014 in Dufferin and Wellington Counties[6]



It should be noted that the graphs above contain crude numbers of ED visits, hospitalizations, and deaths. The Wellington data would be expected to be higher than Dufferin because there are many more people living in Wellington County. In comparing their ranks among all 49 Counties in 2014, Wellington County ranked 31 for opioid-related emergency department visits and Dufferin County ranked 29 (with 1 being highest). In terms of opioid-related deaths in 2013, Wellington County had 10 individuals (ranking 30 out of 49 Counties), and Dufferin did not have available data.

Current Provincial Data

Self-reported opioid use data also provides some context, however it is only available at a provincial level and exhibits interesting downward trends. Self-reported use of prescription opioids among adults over the past 12 months decreased between 2010 (26.6%) and 2015 (22.6%).[7] Similarly, self-reported rates of non-medical prescription opioid use (e.g. recreational use) among adults decreased from 7.7% in 2010 to 4.1% in 2015.[7] Rates of non-medical opioid pain reliever use among grade 7-12 students in Ontario have also declined between 2007 (20.6%) and 2015 (10.0%).[7]

Although the evidence suggests that self-reported opioid use has been decreasing, it is clear that opioid-related adverse events including deaths have escalated provincially. In fact, “between 2005 and 2014, there was a 72% increase in visits to Ontario emergency departments

caused by opioid overdose".[8] It has also been reported that in 2014, over 700 people died from opioid-related causes in Ontario; a 266% increase from 2002.[2] According to the Centre for Addiction and Mental Health's Prescription Opioid Policy Framework:[8]

- "Among adults aged 25 to 34, 12% of all deaths (1 in 8) were opioid-related in 2010 – up from 5.5% in 2001.
- The majority of overdose deaths in Ontario are opioid-related. Relative to other drugs, opioid overdoses are less likely to be deliberate: up to two thirds of deaths from opioid-related causes are accidental
- Other depressants are frequently involved in opioid-related deaths. A benzodiazepine was present in half of opioid-related deaths in Ontario between 1991 and 2010, and alcohol in about 40% of those deaths.
- Just 19% of opioid overdoses involved "inappropriate" administration (meaning the opioid is being used in a different manner than what is recommended, e.g. injection, inhalation, etc.). "[8]

This clearly demonstrates the need for additional provincial and local level data to fully understand the intricacies and impact of the opioid problem. Further exploration of how people use opioids (prescription vs. non-medical) and characteristics of users (e.g., income, education) may also help to inform future education, programs and policies.

Provincial Strategy

In the fall of 2016, the Ministry of Health and Long-Term Care announced *A Strategy to Prevent Opioid Addiction and Overdose in Ontario*.[2,9] This comprehensive strategy has 3 pillars: i) Modernizing Opioid Prescribing and Monitoring, ii) Improving the Treatment of Pain, and iii) Enhancing Addiction Supports and Harm Reduction.

(i) Modernizing Opioid Prescribing and Monitoring

The work of this pillar will include launching a new overdose surveillance and reporting system, and developing evidence-based quality standards for health-care providers. Practice reports will also be made available to physicians through Health Quality Ontario, which will compare opioid prescribing among colleagues.

Education is a large focus of this pillar. For example, new training modules and academic programs will be developed for health-care providers, and public education will be improved to help patients better understand opioid-related risks. Furthermore, this strategy will see the expansion of the fentanyl patch-for patch program across all of Ontario, and high-strength formulations of long-acting opioids will be de-listed from the Ontario Drug Benefit Formulary.

(ii) Improving the Treatment of Pain

The Ministry is dedicated to modernizing chronic pain services and connecting patients to high-quality treatment. This means committing $17 million each year into multidisciplinary teams (including 17 chronic pain clinics across Ontario). It also involves expanding training and support to health-care providers to increase their capacity to safely and effectively treat chronic pain. Moreover, they will expand access and availability of health care services for individuals experiencing low back pain.

(iii) Enhancing Addiction Supports and Harm Reduction
This pillar under the strategy aims to better support patients with opioid addictions and to prevent injury and overdoses. As such, the Ministry will expand access to naloxone (an antidote for opioid overdose) and suboxone (a treatment to relieve opioid withdrawal and drug cravings). Additional activities include: increasing the scope of practice of Nurse Practitioners to enable them to prescribe suboxone; collaboration with Indigenous mental health and addiction initiatives to ensure culturally appropriate initiatives; and improving the integration of primary care, mental health and suboxone/methadone treatment to better support those with an opioid addiction. Finally, harm reduction is highlighted within the strategy to collaborate with experts and municipal leaders to develop evidence-based hard reduction frameworks. This may include expansion of needle exchange programs and supervised injection sites.

Role of Public Health

As noted in the Strategy above, the first two pillars clearly relate to clinical practices of health care providers and increasing access to appropriate pain treatment programs and services. The current Ontario Public Health Standards (OPHS, 2008) does not include a mandate to provide clinical advice to health care providers on prescribing practices for pain reduction. [3] This is the reason why Public Health is not involved in recommendations for medical marijuana. However, the third pillar does speak to areas related to the OPHS. For example, there are two areas under the OPHS where substance misuse is referenced: i) Prevention of Injury and Substance Misuse, and ii) Sexual Health, Sexually Transmitted Infections, and Blood-Borne Infections (HIV).

(i) *Prevention of Injury and Substance Misuse*
This standard dictates the role of Public Health as assessment and surveillance, and health promotion and policy development. The standard also recommends increasing public awareness about risk, protective and resiliency factors associated with substance misuse, the community impact associated with substance misuse, and current legislation.

In the last two years, the focus within this standard at WDGPH has been alcohol and marijuana; producing research reports, reviewing and recommending proposed polices changes, creating health communication materials, and mobilizing community partners through community coalitions. Moreover, WDGPH continues to address misuse of all substances by increasing youth resiliency through partner training and consultations, and addressing underlying social determinants of health (e.g. poverty taskforce).

Moving forward, WDGPH can contribute to the provincial opioid strategy by analyzing available local data (where available) and presenting this information to increase public and community partner awareness in order to help inform community partners' programs and policies. Working on opioid health promotion activities will require a population health approach and balanced against prioritized work in alcohol and marijuana, which have been identified as the two largest misused substances in WDGPH.

(ii) *Sexual Health, Sexually Transmitted Infections, and Blood Borne Infections*
This standard also dictates the work of Public Health in the areas of assessment and surveillance, health promotion and policy development, and disease prevention/health protection. This standard clearly articulates that public health will engage community partners and priority populations in the planning, development, and implementation of harm reduction

programming, and that Public Health will ensure access to a variety of harm reduction program delivery models based upon local surveillance

Currently, WDGPH works collaboratively with community partners on a harm reduction strategy. WDGPH has a service agreement with ARCH to provide harm reduction materials and in return, ARCH oversees the needle-exchange program and provides outreach services. The needle exchange program involves the distribution of new syringes, crack pipes and other drug paraphernalia, along with the collection and disposal of used syringes. Community partners also offer counselling and support at on-site locations or through community outreach, and naloxone kits and appropriate training. From July to December 2015, 111,626 clean needles for injection drug use were distributed into the community.[10] The return rate of used needles was approximately 32% for the year.[10] This return rate should be analyzed with caution however, as individuals may return to other sources not covered under the needle exchange program (e.g. pharmacies).

Specific to WDGPH, harm reduction materials are available at each office location and the public can access a Public Health Nurse should they need education or referral to services. Public Health will continue to monitor the use and distribution of these materials and blood-borne infection data in order to be responsive to community and partner needs. Nevertheless, should local data demonstrate that additional community harm reduction services are required (e.g. safe injection sites), WDGPH will support community partner agencies that are more directly involved with priority populations on a daily basis through their outreach programs, and/or community agencies that are specialists in addictions and/or mental health in establishing these sites within their agency.

Conclusion

Opioid prescribing has been on the rise, and local and provincial statistics on opioid-related harms present a troubling picture. The province should be commended for taking action and setting priorities to prevent opioid addiction and overdoses in Ontario.

WDGPH is committed to examining current opioid use in the community and working with partners to identify existing programs/services and assessing where gaps may exist. For instance, the Wellington Guelph Drug Strategy is currently undergoing strategic planning and WDGPH will continue to provide support and expertise in this endeavor. A Board of Health report will be presented in spring 2017 to outline our progress and any next steps.

Ontario Public Health Standard

Prevention of Injury and Substance Misuse

Board of Health Outcomes
The board of health is aware of and uses epidemiology to influence the development of healthy public policy and its programs and services for the prevention of injury and substance misuse.

- There is an increased awareness of community partners about the factors associated with injury and substance misuse required to inform program planning and policy development, including the following:
    - Community health status;
    - Risk, protective, and resiliency factors; and
    - Impact.
- Policy-makers have the information required to enable them to amend current policies or develop new policies that would have an impact on the prevention of injury and substance misuse.
- Community partners are engaged in the prevention of injury and substance misuse. • The public is aware that the majority of injuries are predictable and preventable.
- The public is aware of the risk, protective, and resiliency factors associated with injury and substance misuse.
- The public is aware of the impact associated with injury and substance misuse.
- Priority populations have the capacity to prevent injury, substance misuse, and associated harms.
- The public is aware of current legislation related to the prevention of injury and substance misuse.

Sexual Health, Sexually Transmitted Infections, and Blood-borne Infections (including HIV)

Board of Health Outcomes

- The board of health achieves timely and effective detection and identification of cases of sexually transmitted infections and blood-borne infections, and their associated risk factors and emerging trends.
- The board of health is aware of and uses epidemiology to influence the development of healthy public policy and its programs and services to promote healthy sexuality and to prevent or reduce the burden of sexually transmitted infections and blood-borne infections.
- The public is aware of risk, protective, and resiliency factors related to healthy sexuality and the prevention of sexually transmitted infections and blood-borne infections. Blood-borne infections include hepatitis B, human immunodeficiency virus (HIV), and hepatitis C. Blood-borne infections are transmitted to the blood through sexual activities/intercourse and by the sharing of injection equipment and other drug-related activities. HIV is specified only in the title but is implied throughout the Program Standard in all sections referring to sexually transmitted infections and blood-borne infections.
- Community partners are aware of the importance of having supportive environments to promote healthy sexuality and prevent sexually transmitted infections and blood-borne infections.
- Priority populations have the capacity to adopt behaviours related to healthy sexuality and the prevention of sexually transmitted infections and blood-borne infections.
- The board of health manages reported cases and contacts of sexually transmitted infections and blood-borne infections.
- Health care providers have the capacity to manage cases and contacts of sexually transmitted infections and blood-borne infections.
- Priority populations have access to sexual health services, including contraception and comprehensive pregnancy counselling.

- Priority populations have access to harm reduction services to reduce the transmission of sexually transmitted infections and blood-borne infections.

WDGPH Strategic Direction(s)

Check all that apply:

☒ Building Healthy Communities
We will work with communities to support the health and well-being of everyone.

☐ Service Centred Approach
We are committed to providing excellent service to anyone interacting with Public Health.

☐ Health Equity
We will provide programs and services that integrate health equity principles to reduce or eliminate health differences between population groups.

☐ Organizational Capacity
We will improve our capacity to effectively deliver public health programs and services.

Health Equity

There is limited available data about prescription and non-prescription opioid use across various population groups. This means it is difficult to compare rates of opioid use and adverse effects of opioid use across income, education, ethnicity and other social determinants of health.

However, there is literature regarding health equity and access to prescription drugs. In Ontario, many working-age individuals have access to prescription drugs through workplace insurance plans.[9] In addition, prescription drug benefits are extended to certain populations, such as those on social assistance, seniors and others with specific diseases that carry high drug costs.[11] Nevertheless, many adults that are employed part-time, have vicarious employment or are considered the working poor, lack drug coverage and cannot afford the prescription drugs they may need.[11] In fact, "twenty-two percent of drugs are paid for out of pocket and this cost disproportionately falls on low-income individuals and their families. Low income families are far less likely to have employer-provided coverage than higher income families, and are also more likely to have chronic medical conditions requiring ongoing treatment."[11]

This lack of access can pose health equity concerns, as individuals that can't afford medically necessary prescription drugs may have to pay out of pocket, which then forces individuals and families to face the difficult choice of paying for necessary prescriptions or sacrificing other household expenses, such as food and rent.[11] In the case of opioids, it would be prudent to examine whether some individuals who legitimately need prescription opioids turn to non-prescription opioids (either due to cost or ability to buy single doses), which in turn poses significant health risks.

Finally, access to the certain health care services may not be equitable. For example, access to health care services that can help relieve or prevent chronic pain (e.g. exercise programs, physio, etc.) may not be available to people of low-income, potentially causing them to turn to opioids that are available through the ODB program. There is also evidence that access to health care services, such as addiction programs, has traditionally been inequitable across certain population groups (e.g. race, sexual orientation, immigration status, income and education).[12] With regard to income, long wait lists have been cited as a barrier to accessing publically funded addiction programs and services, when compared to programs that are available for a fee or covered by private insurance plans.[12] It is the hope that the provincial opioid strategy will address these inequities by increasing access to appropriate pain management programs, and addiction and harm reduction services.

Appendices

None.

References

1. Gomes T, Mamdani MM, Petrson JM, Ghalla, IA, Juurlink DN. Trends in high-dose opioid prescribing in Canada. *Can Fam Physician* [Internet]. 2014. [cited 2017 Jan 16]; 60(9): 826-832. Available from: http://www.cfp.ca/content/60/9/826.full

2. Ontario. Ministry of Health and Long-Term Care. A strategy to prevent opioid addiction and overdose in Ontario. [Power Point presentation] 2017.

3. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards. [Internet] 2008. [cited 2017 Jan 16]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

4. Gomes T, Juurlink DN. Opioid use and overdose: what we've learned in Ontario. *Healthc Q*. [Internet] 2016. [cited 2017 Jan 16]; 18(4): 8-11. Available from: http://www.longwoods.com/content/24568

5. Kirkup, K. Canada must examine why it tops opioid-consuming countries: Health Minister Jane Philpott. [Internet] The Canadian Press. 2016 Jul 26. [cited 2017 Jan 16]. Available from: http://www.cbc.ca/news/politics/opioid-canada-us-philpott-1.3695805

6. The Ontario Drug Policy Research Network. Opioid use and related adverse events in Ontario. [Internet] 2016. [cited 2017 Jan 16]. Available from: http://odprn.ca/wp-content/uploads/2016/11/ODPRN-Opioid-Use-and-Related-Adverse-Events-Nov-2016.pdf

7. Ialomiteanu AR, Hamilton HA, Adlaf, EM, Mann RE. CAMH Monitor e-Report: substance use, mental health and well-being among Ontario adults, 1977–2015 (CAMH Research Document Series No. 45). [Internet] 2016. [cited 2017 Jan 16]. Available from: www.camh.ca/en/research/news_and_publications

8. Centre for Addiction and Mental Health. Prescription opioid policy framework. [Internet] 2016. [cited 2017 Jan 16]. Available from: https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/CAMHopioiddpolicyframework.pdf

9. Ontario. Ministry of Health and Long Term Care. Backgrounder: strategy to prevent opioid addiction and overdose. [Internet] 2016 October 12. [cited 2017 Jan 16]. Available from: https://news.ontario.ca/mohltc/en/2016/10/ontario-taking-action-to-prevent-opioid-abuse.html

10. Wellington-Dufferin-Guelph Public Health. Needle/Syringe Exchange Program Activity Report 2015.

11. Wellesley Institute. Access to prescription drugs – HEIA in the federal election. [Internet] 2015. [cited 2017 Jan 16]. Available from: http://www.wellesleyinstitute.com/wp-content/uploads/2015/10/PrescriptionDrugsHEIA-UPDATE.pdf