META:PHI MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION — PARTNERS IN HEALTH INTEGRATION

NEWSLETTER

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PROGRAM INNOVATION

Mobile Crisis Response Team

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It is estimated that up to 90% of calls to police include some form of mental health, addictions, or domestic-related distress. These situations can be challenging for police officers without specialized training in responding to mental health crises.

Brightshores Health System's Mobile Crisis Response Team (MCRT) program was launched in November 2022. The team, with training and experience in crisis intervention, consists of mental health and addictions professionals with backgrounds in nursing, social work, and psychotherapy. These highly trained clinicians have partnered with the Ontario Provincial Police (OPP) in Grey and Bruce Counties to provide a collaborative approach to assisting individuals experiencing a mental health and/or addictions crisis in the community.

MCRT works in partnership with Grey Bruce OPP and South Bruce OPP and have a clinician embedded in each of the Chatsworth, Kincardine and Wiarton detachments. South Bruce OPP use a ride-along model where the MCRT clinician accompanies the officer to calls for service in the officer's police vehicle. Grey Bruce OPP use a model where the MCRT clinician meets officers at the scene in their own vehicle. The decision to use either model depends on factors, including size of the catchment area, population and travel distance.

The goals of the MCRT program include ensuring timely and preventive interventions for persons in distress; avoiding unnecessary police apprehensions and emergency room visits, as well as diverting individuals from unnecessary involvement with the criminal justice system. When a 911 call is received, OPP officers and MCRT respond together, on-scene, to provide immediate assessment, support and intervention to persons in crisis, their families, and/or caregivers. MCRT clinicians attend live calls with OPP to support persons in crisis and support the responding officers to create a more recovery-focused and client-centered approach to mental health care. The clinicians provide crisis intervention, including de-escalation and assessment, community referrals, follow-up supports, and assistance in connecting to other services which include Brightshores RAAM clinic, and Withdrawal Management Services. The MCRT clinicians also provide support in hospital emergency rooms to facilitate efficient police/hospital transitions if/when hospital admissions are required.

This collaborative approach provides a more compassionate, appropriate and effective process for supporting individuals experiencing a mental health crisis. The MCRT program has received positive responses from both OPP officers and community members. Connection with appropriate mental health supports, de-escalation and reduced recidivism underscore the value of the collaboration between OPP and Brightshores Health System's MCRT program. We hope this successful collaboration continues to help build trust and bridge existing gaps between law enforcement and those who experience mental health and substance use crises.

FACES FROM THE FIELD

Lorilee Savard
Freelance Writer
META:PHI Community Consultant
Person with Lived Experience

My name is Lorilee - mother of 2, grandmother of 9, freelance writer, and person with A LOT of lived experience. My favorite motto is 'if you don't deal with your demons, your demons will deal with you!' This is my story of addiction and recovery.

Let's rewind to 2017. I was in the thick of my addiction. Morphine had become my only love. I worked my way up to snorting 600-700mgs of it a day, as well as using oxycontin, hydromorphone and whatever else I could get my hands on. This quickly led to injecting, and I couldn't get enough. It consumed my life, and I became someone that wasn't me, someone who couldn't be trusted, someone who only cared about getting more pills so I wouldn't get 'dope sick'. That's what drives addiction: you have to get more, more, more or you get sick, sicker than anything you could possibly imagine! I had already had numerous hospital visits over the years, and I had been in detox many times. If only I had known then what I know now: that the connection between opiates and PTSD culminated in my having a disease I had never even heard of, Opioid Use Disorder (OUD).

The last time I went to detox was one of the most horrible experiences of my life. I was sent there from a hospital emergency room in a taxi at 3 am - sick, scared, and alone. I was put in a room with one bathroom and 5-6 people, all of whom were also detoxing. It was absolutely horrible! One day I decided I'd had enough, and escaped over the fence, hitchhiking back to my little hometown. 'I'm done', I thought. I owed a lot of money to some scary folks who were looking for me. I was getting kicked out of my apartment for not paying my rent, and I was so dope sick I could barely walk. (You get restless cramped leg syndrome so badly you want to chop off your legs.) My life had become a nightmare: I was alone, heavily addicted, and determined to end it all.

The town where I lived had a river with very high rock cuts above it. I picked out the perfect spot to jump from, where there would be no chance of survival. On the fateful day, I wrote a suicide note, put on my favorite leather jacket, and away I went. Then, on my way to the river, something caught my eye: a building with a new sign that read 'Addictions and Mental Health' and a small sign on the door, '*Please ring bell*'. I don't know what made me do it, but I walked over and I pushed that bell, and an angel named Sabrina opened the door. I can't tell you enough how this woman helped me.

Within two weeks I was in the office of a wonderful addictions doctor. I left that day with a 6-week prescription for suboxone. However, I found it wasn't really doing anything for me, and I continued to experience very severe cravings, and terrible leg cramps. So my doctor switched me to methadone and I haven't looked back since! Methadone maintenance, along with addictions and mental health supports saved my life. I even got help with housing. Methadone has made my life manageable; I'm stable and working my way back to the person who is ME!

A lot has changed since I hopped over that fence at the Kingston detox. The language about addiction is different, and the stigma is gradually being reduced. It is so much better now than it was 5 or 6 years ago. Then I was told, 'It's your own fault'. 'You're a junkie.' 'You deserve everything that's happening to you.' Not anymore. While my life-saving doctor has since left her practice, I am now under the care of an incredible team. Methadone maintenance has absolutely saved my life. I feel human again.

Whatever happened to the people looking for me, you ask? Well, that's a story for another day.

META:PHI CLINICAL RESOURCE SPOTLIGHT

Recommendations for the Use of Slow-release Oral Morphine as Opioid Agonist Therapy

PERSPECTIVES

OAT Initiation After Hospital Visits for Opioid Poisonings in Ontario

Tina Hu MD MSc
Assistant Professor, University of Toronto

This is a precis of an article published in the December 2023 edition of the Canadian Medical Association Journal on rates of OAT initiation in emergency departments and hospitals from 2013 to 2020 for individuals following an opioid overdose. The full article can be found here.

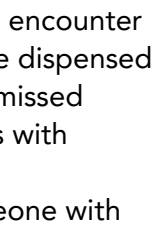
In the midst of the opioid public health crisis, there were 7,328 deaths from opioid overdose in Canada in 2022 alone. Opioid-related hospitalizations increased 32% between 2016 and 2021, and in Ontario, opioid-related emergency department (ED) visits increased 286%. Among patients presenting to the ED with nonfatal opioid overdose, close to 5% die within 1 year. Emergency department visits and hospital admissions for opioid toxicity are opportunities to initiate opioid agonist therapy (OAT), which reduces both morbidity and mortality in patients with opioid use disorder (OUD). Previous research has shown that patients are more likely to continue treatment if OAT is started in the emergency department than if they are referred for outpatient treatment.

A 2018 Canadian clinical practice guideline was the first national guideline to recommend buprenorphine–naloxone as first-line treatment to reduce the risk of toxicity and facilitate safer take-home dosing. Methadone is recommended as second-line treatment when patients respond poorly to buprenorphine–naloxone or if it is not the preferred option for another reason. Slow-release oral morphine can be considered as third-line treatment when buprenorphine–naloxone and methadone are ineffective or contraindicated yet patients remain at high risk of opioid-related harms. To examine the impact of the OUD management guidelines on OAT initiation rates, we conducted a retrospective, population-based serial cross-sectional study of hospital encounters for opioid toxicity among patients with OUD between January 1, 2013 and March 31, 2020 in Ontario. We followed individuals for up to 7 days from discharge. The primary outcome was OAT initiation (methadone, buprenorphine/naloxone, or slow-release oral morphine) within 7 days of discharge, measured quarterly.

Among 20,702 individuals with OUD who presented to hospital with opioid toxicity, the median age was 35 years, and 65.1% were male. Over the study period, 4.1% (n=851) initiated OAT within 7 days of discharge from hospital. We also reported that almost 20% of opioid overdoses led to outpatient clinic visits and repeat emergency department visits in the 7 days after the index hospital visit, which is the time frame associated with very high mortality risk after an overdose. Despite this connection to healthcare services, these patients did not receive OAT, which highlights the critical missed opportunities to engage patients in treatment to prevent future mortality and morbidity related to opioid use.

In summary, among Ontarians with a hospital encounter for opioid toxicity, despite rising prevalence over time, only 1 in 18 were dispensed OAT within a week of discharge in early 2020. These findings highlight missed opportunities to initiate therapies proven to reduce mortality in patients with OUD and indicate that treatment guidelines need to be paired with effective knowledge translation.

Thoughts from a Semi-Retired Addiction Doctor



Addiction medicine: Healthcare's Orphan

Meldon Kahan MD CCFP FRCPC
Medical Director, META:PHI

In this Newsletter, Dr Hu has written a summary of her retrospective cohort study on visits to Ontario EDs by patients with Opioid Use Disorder. Her conclusion is an indictment of our health care system: "Among Ontarians with a hospital encounter for opioid toxicity, despite rising prevalence over time, only 1 in 18 were dispensed OAT within a week of discharge in early 2020. These findings highlight missed opportunities to initiate therapies proven to reduce mortality in patients with OUD".

This is bizarre when you think about it. Once EDs have stabilized someone with an acute, life- threatening condition, they prescribe medications as needed and arrange outpatient follow up. The ED patient with severe asthma is sent home with inhalers and an appointment with a respirologist. Yet it appears that the patient who has overdosed on fentanyl is often sent home with nothing – no naloxone kit, no prescription for buprenorphine or methadone, no referral to a RAAM clinic or withdrawal management service.

So why is this? Why aren't EDs treating opioid emergencies with the same care and attention as they treat other emergencies? It's not because ED interventions are ineffective. Randomized trials have shown that patients who receive buprenorphine in the ED are much more likely to engage in community buprenorphine treatment than those who were simply counselled to get treatment. Nor is it because of the treatments themselves; buprenorphine and methadone are effective at reducing mortality, and are safe and fairly simple to prescribe.

The problem is that the healthcare system as a whole does not view addiction as a medical issue and has not taken responsibility for its management. Medical schools and residency programs provide minimal training in addiction. Very few hospitals have addiction services.

The good news is that the groundwork has been laid for change. People in the healthcare system – from front-line healthcare workers to administrators – are no longer complacent; they recognize that something must be done. And a small but growing cadre of physicians, nurse practitioners, counsellors and administrators are working to implement change: RAAM clinics, withdrawal management services, and community addiction programs are adopting new and innovative addiction treatments.

But changing ED practices is complex and difficult. ED nurses and physicians need to be trained in OAT protocols. Opioid agonist medications need to be added to the ED formulary. Change needs to be facilitated by a peer worker, patient navigator and/or addiction consult service. EDs need a nearby RAAM clinic to provide ongoing OAT.

Sadly, few hospitals have an organized, well-resourced group of addiction clinicians that sit on powerful hospital committees. And hospitals, like all healthcare services, are facing increasing demands for services. So progress has been uneven and slow – but real. Every region of Ontario has EDs and RAAM clinic that are beginning to implement life-saving addiction treatment, with northern communities leading the way. And these successes are due to local champions who are idealistic, dedicated, persistent and courageous – the heroes in battling this scourge of the century.

EVENTS

2024 Webinar Series - Session #1
Treating Tobacco Use Disorder - Dr. Milan Khara
Wed Feb. 21, 7-8:30 pm Register **HERE**

RAAM Monthly Videoconference Dialogue Series NEW
Follow-up to Jan 17 webinar 'Introduction to Methadone Prescribing'
Tuesday Feb 6, 8-8:45 am

Addiction NP Videoconference Discussion
Wed Feb 28, 12-1 pm
To join any of these events contact laurie.smith@wchospital.ca