Responding to the overdose crisis in small and medium sized BC communities

Tara Fitzgerald – Director special projects (opioid response)

Paul Hasselback – Medical Health Officer

island health

outline

- The rural overdose issue
- ‘More’ unique rural features
- Rural response challenges

Definitions

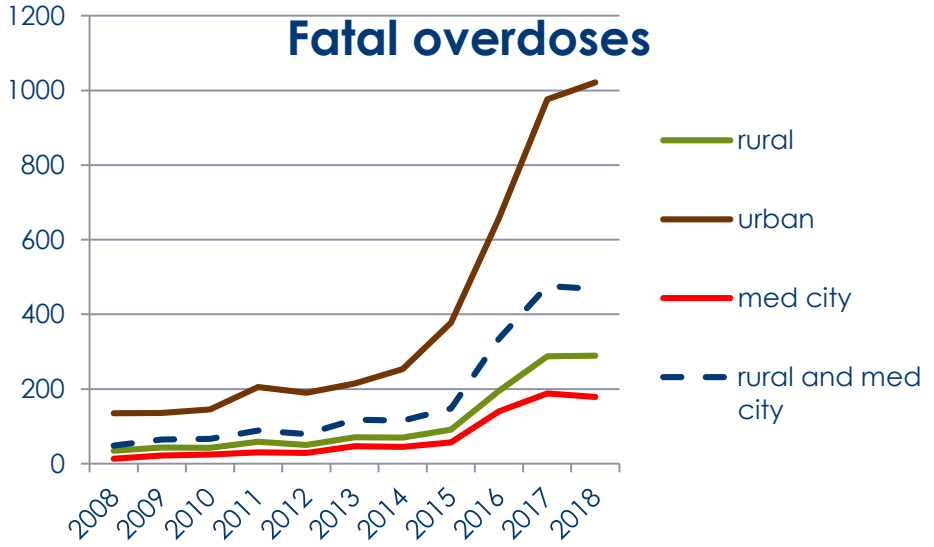
- Rural HSDAs, Central Vancouver Island, East Kootenay, Kootenay Boundary, North Shore/Coast Garibaldi, North Vancouver Island, Northeast, Northern Interior, Northwest, Thompson Cariboo Shuswap – minus four mid sized city LHAs.
- Med. City (LHAs) Central Okanagan, Greater Nanaimo, Kamloops, Prince George
- Urban HSDA – Fraser East, Fraser North, Fraser South, Richmond, South Vancouver Island, Vancouver,

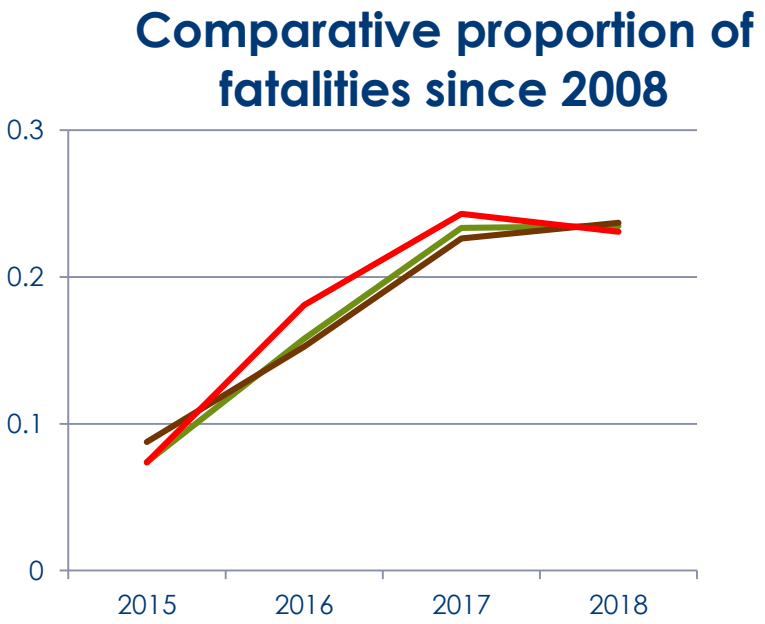
A significant minority

- One-third of overdose fatalities happening outside Lower mainland, south island
  - 40% of rural in 4 med. cities
- Rates in Okanagan*, Thompson-Caribou*, Central* and North Island, Northern Interior* and Northeast
  - above provincial average
- Own private residence - 70% in all rural areas
  - 54% in urban areas
- 22% female (18% urban)

* geographies where med cities are located

Distribution of overdoses





Issues

- Small "separation" distance from substance use services to businesses and residential areas
- Rapid transition from hidden problem to local crisis
  - Less compassionate response?
- Community fear dominates discourse – discarded needles, aggressive and unusual behaviours, public aggregation around service sites, and affects whole community

Issues

- Many rural local governments priority Economic survival
  - homelessness and housing issues may collide
- "social planning" and social services rudimentary
- Health Authorities may have existing rural/urban equity issues.
- What does equitable distribution look like?
  - Harm reduction supplies
  - Naloxone distribution
  - Substance use clinical staff
  - Rapid access clinics
    - OAT, iOAT
  - Overdose prevention sites/SCS
  - Mental Health services
  - Access to in-community sobering and residential treatment

Issues

- High proportion of resource-based industries
  - Known higher risk.
  - Trades and transport – urban equivalent?
  - Police checks not required.
- Pre-existing higher alcohol substance use.
- Substance use hospitalization higher
- Prior known prescription drug issues
- Boom bust economies

Community infrastructure

- Limited capacity. Same people, different issue.
- Generalists.
  - Specialized services limited, even in med. cities
  - Most addiction medicine provided by family physicians, some focused practices in med. cities.
  - Addiction medicine was not central in past medical training

OAT growth disproportional

Growth since Jan 2016	Prescribers	Clients
• Rural 2928 to 4627		58%
▫ Rx (60 – 297)	395%	
• Mid-cities 1768 to 2773		57%
▫ (30 to 92)	207%	
• Urban 11433 to 14881		30%
▫ (233 to 508)	118%	

- Rural rates of prescribing 25% less than urban, while 40% more prescribers
- Med cities now mirror urban after increase

Stigma

- Social connection opportunities vary
  - ostracization dominates as services not designed for those with substance use disorder (eg lower barrier housing)
- Neighbourhoods are able to demonstrate negative impacts
- Rural deaths may impact a whole community – added bereavement support needs

Overdose planning

- CISUR community guide workbook starting point
- CATs and DOGs (dedicated overdose groups)
- Peers and peer based organizations less well-established
  - Fewer supports for current users and those in recovery
- Case management and linkage to OAT easier
- Prevention and recovery guidance
  - Housing availability and policies
- Inclusion of community safety discussions
- Corrections releases - continuity of service unlikley

Indigenous communities and planning

- Disproportionate burden (FNHA, Coroner, OERC studies)
- Intergenerational issues increase substance use
- Triple provincial fatality rates, five times events
- Demographic differences (F=M)
  - high female impact (7-8 times fatalities, 5 times events)
- Dependant on pre-existing relationships in rural areas and med cities, likely high variation
- Deaths in urban settings may be trauma for whole home community
- Variable acceptance within community

Recommendations

- Improve integration of indigenous perspectives
- Focused rural peer CIE training programs (compassion, inclusion, engagement)
- Need for a rural overdose action exchange
  - Include local government leadership
  - Rural based persons with lived experiences.
  - Front line generalist care provider involvement
- Subanalysis of provincial cohort looking a rural specific issues
  - Interaction with health systems, prescription histories, occupation
- New model for recovery supports

Tara Fitzgerald
Director - special projects
250.850.2100 x62971
Tara.Fitzgerald@VIHA.CA

Paul Hasselback MD MSc FRCPC
250.739.6304
Medical Health Officer
Central Vancouver Island
paul.hasselback@viha.ca