PAN 2016 Executive Directors Summit
October 25, 2016 from 1:00pm to 2:30pm
Draft Notes on Roundtable Discussion: Fentanyl Crisis

Facilitated by Vicki L. Nygaard

Key Questions: What are the impacts of the fentanyl overdose crisis on frontline service organizations, staff and clients? What supports are helpful for the frontline workers?

Three themes emerged from this discussion:
Need for much more (1) consistency; (2) coordination; and (3) support.

Consistency and Coordination

- Inconsistencies in messaging around who can get naloxone kits, when, where, for whom, and what happens when someone does not follow the "rules."
    - Challenging when people need naloxone kits but they are only meant for those who use opioids. E.g. Those who fear for someone in their community of care don't want to ask for kits because they fear repercussions.
- Some service providers give out kits as needed and do not get in trouble from CDC while others are constantly on the radar and "getting their hands smacked."
- Fentanyl ODs are not just happening to folks who use opioids regularly but also to those who use irregularly. Kits are not consistently available in all pharmacies for purchase, even if people could afford it and if they would take the precautions (which they don't because their recreational use is spontaneous – e.g. at a party while drunk, etc.).
    - Some pharmacies won't stock the naloxone kits because they come in cases of ten and they feel they couldn't use ten in time before the expiry date. Too pricey.
- Heather from AVI stated that there is a company that can distribute naloxone for $1.50 per dose.
- Discussion around sharing policies on harm reduction, etc. between organizations – organizations that do not have their own harm reduction policies can use others as guidance and not recreate the wheel.

- "Policy will follow good practice." This quote was in response to the idea that there was no policy on how to deal with the OD crisis so people were making it up as they went along and in some cases, government organizations were saying "sure, carry on... seems to be working." This was frustrating to many people at the table as they are operating without knowing how much risk they are taking and concerned about potential repercussions such as funding cuts or shut down of services.
- Doctors and Nurse Practitioners often seem to not know the rules and regulations around the Take Home Kits and/or the dispensing thereof.
- People often do not want to write on a form that they are currently using drugs, especially as they have no idea where this information will go and what implications there could be from this sort of information being shared/floating around. Service providers often tell people that no one will get the info except CDC but really… can they be sure? For this reason, one organization writes "past user" on the forms regardless of whether or not people are current users or aren't even users at all but they want a kit for child who is at risk. Some people who need/want the kits for others are slightly more comfortable saying they <u>were</u> a user. Much frustration that people have to lie to save lives. Service providers, friends and family members.

<u>Support</u>

- More support is needed for frontline staff.
- More education is needed for people that "breathing" will save lives, not just naloxone. People need CPR training especially if they can't get the kits.
- The learning from the frontline and the information shared here at the table around what is problematic should be shared with the Harm Reduction Coordinators at the government health level – they could/should be repositories for feedback.
- There are some real barriers and issues experienced by frontline service providers, for example they have no time in their days/weeks to provide the amount of training they get asked for and yet cannot say no because it could mean someone could die. Also, if people engaged in high-risk activities come in and ask for training, the organization cannot ask them to come back another time, days later. Cannot reschedule.
- Staff need more support as they are dealing with clients who are being traumatized over and over.
- Clients who use the kits are traumatized – would it work to start a First Responders Support Group? What about those who have experienced an OD? Would a support group for them be helpful? There could be a prevention/education component to it. Peer support groups and the buddy system may be helpful as well. One organization runs a monthly grief and loss group that has, *de facto*, become a vehicle for people who have experienced an OD and for others too.
- Need more protective measures for and acknowledgment of PTSD (post traumatic stress disorder).
- Capacity building needs to happen. Some organizations already provide training to other orgs and to clients at set monthly times, and sessions are geared to who is actually there (e.g. AVI does this).

- Train-the-Trainer workshops and skills sharing/training sessions could be helpful; work on this with the Health Authorities. The “By the Book” training provided by the CDC needs to be supplemented by the real front line experiences of people.
- “It’s easier to beg forgiveness than to ask permission.” This quote is in response to the harm reduction frontline service agencies doing “whatever it takes” to save lives, regardless of the rules.
- Being a first responder takes a toll on people. They all need support. Need counselling help for staff and any other frontline responders including people who use drugs (PWUD).
- Advice for people to check out the discussion paper “Toward the Heart” for advice on supporting staff after administering naloxone.
- People felt they wanted “drills to build skills,” as in, even with the training, until you’ve had to physically deal with an OD, unsure how things will go. Training with a practice component would increase people’s confidence about intervening.
- Discussion about when an OD happens at an organization, do the service providers clear the space, get people in the waiting rooms to help, or what? There was disagreement about what was best. Agreement that each org probably should put whatever works for them into place.
- Discussion about “the debrief” post OD. Some people feel it re-traumatizes them and want no part of it and others need to take time away first and others need the support immediately after.
- These ODs and OD deaths are emotionally taxing, leading to major burnout and guilt (when people do engage in self care), and are stressing leadership in organizations.
- If peers were to distribute naloxone, realistically how would that look/work?
- Maybe a monthly de-brief/sharing with many orgs would be helpful.
- One organization puts their frontline staff “stress/trauma” time off needs as PTSD claims through WCB (Workers Compensation Board) now… and there are many. Puts a lot of pressure on WCB who (hopefully) will put political pressure on the government for increased support.