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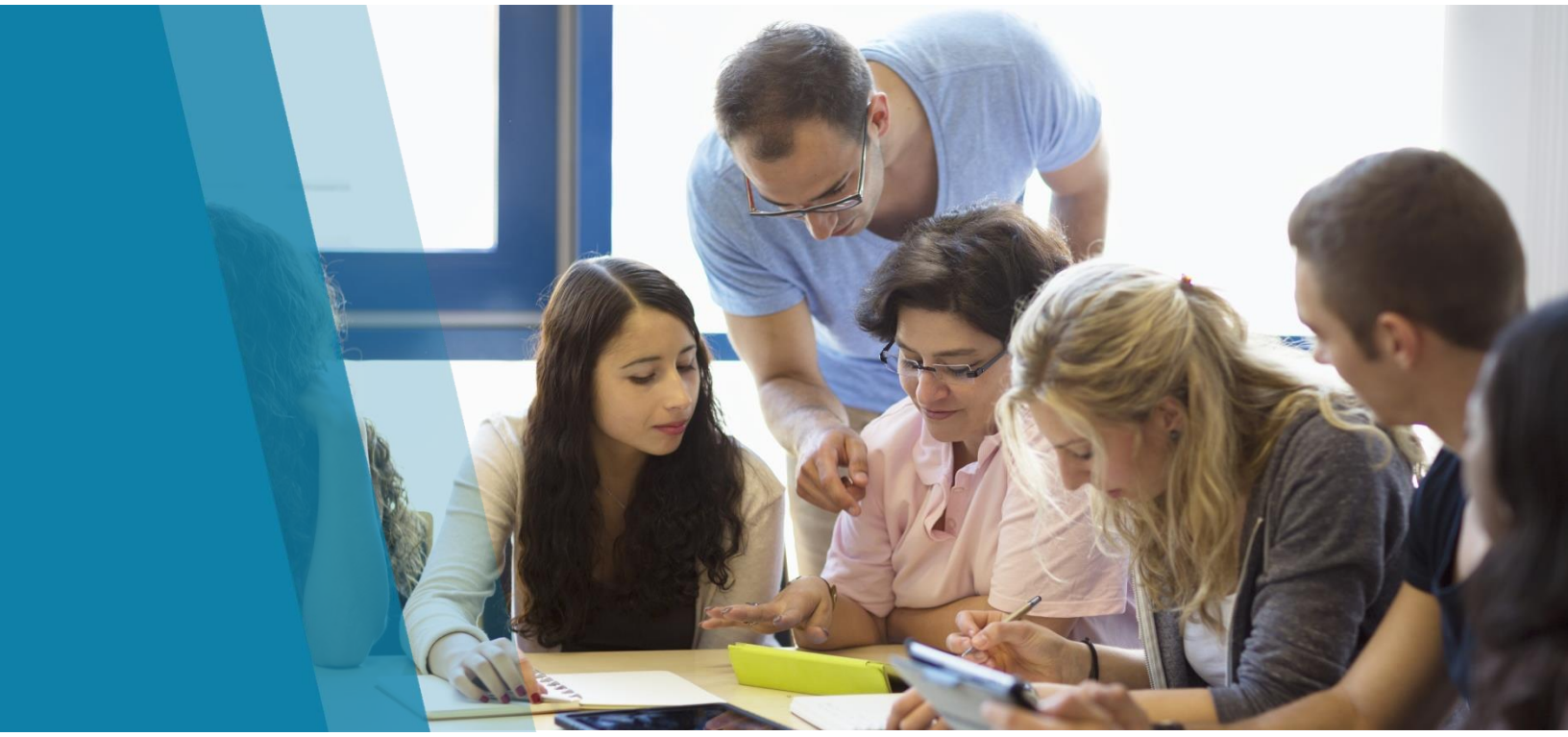
Applying situational assessment skills to address opioid-related harms: Workshop report



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Disclaimer

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Contents

List of abbreviations

ACES - Acute Care Enhanced Surveillance

BIA - Business Improvement Areas

CAMH - Centre for Addiction and Mental Health

CCHS - Canadian Community Health Survey

CDAS - Community Drug and Alcohol Services

CDS - Community Drug Strategy

CMOH - Chief Medical Officer of Health

CPSO - College of Physicians and Surgeons of Ontario

DAD - Discharge Abstract Database

ED - Emergency Department

EDI - Early Development Instrument

EIDM - Evidence-Informed Decision Making

EMS - Emergency Medical Services

GIS - Geographic Information System

HBHC - Healthy Babies Healthy Children

ICU - Intensive Care Unit

IMS - Incident Management System

iPHIS - Integrated Public Health Information System

KAP - Knowledge, Attitudes and Practices

LGBT - Lesbian, Gay, Bisexual, Transgender

LHIN - Local Health Integration Network

MOHLTC - Ministry of Health and Long Term Care

NACRS - National Ambulatory Care Reporting System data

NCCMT - National Collaborating Centre for Methods and Tools

NPS - Novel Psychoactive Substances

NEP - Needle Exchange Program

NSP - Needle and Syringe Program

OATC - Ontario Addiction Treatment Centres

ODB - Ontario Drug Benefit

ODPRN - Ontario Drug Policy Research Network

ONP - Ontario Naloxone Program

ONPP - Ontario Naloxone Program for Pharmacies

OPHS - Ontario Public Health Standards

OSDUHS - Ontario Student Drug Use and Health Survey

PHO - Public Health Ontario

PHU - Public health unit

PWUD - People who use drugs

RRFSS - Rapid Risk Factor Surveillance System

SDOH - Social Determinants of Health

SES - Socioeconomic status

SWOT - Strengths, Weaknesses, Opportunities and Threats

WSIB - Workplace Safety and Insurance Board

Introduction

Opioid prescribing and opioid-related harms have increased in Ontario over the past two decades. In response, comprehensive strategies to address opioid-related harms are developing in many jurisdictions, including at local and provincial levels in Ontario.

Public Health Ontario (PHO) held a one-day workshop to build local capacity in skills for conducting a situational assessment and identify key considerations for applying these methods to inform local planning to address opioid-related harms.

The specific objectives of the workshop were to:

1. Increase knowledge and skills in conducting situational assessments.
2. Consider how to apply situational assessment skills to the issue of opioid-related harms.
3. Identify key considerations in undertaking and gathering information for a situational assessment to inform program planning to address opioid-related harms.

Workshop attendees

This event convened 33 individuals from 21 local public health units (PHUs) in Ontario interested in developing skills in situational assessment and considering their application to address opioid-related harms in their communities. Attendees also included PHO staff (nine facilitators/attendees) and the Ministry of Health and Long Term Care (one attendee). The meeting included public health professionals from urban, rural and Northern health units who hold various roles, including Medical Officers of Health, Health Promoters, and Epidemiologists.

> **How to use this report**
>
> **The report is intended to share discussion summaries, presentations and panelist experience from the workshop. The information presented in this report can help support local PHUs to apply systematic methods for situational assessments to inform community action plans to reduce opioid-related harms in the local population.**

Reporting methods

The information contained in this report and appendices are based on presentation slides, note-taking and small group discussion summary materials. Presenters provided permission to include their slides in the appendices or reviewed and confirmed the summary notes of their presentations. Following the workshop, we transcribed all notes, verified content and permissions with presenters, and collated notes according to discussion topics. We did not further synthesize or perform qualitative analysis using these notes, as attendees indicated at the workshop they preferred to use the direct notes with more details for them to consider in their specific local context.

Research has shown that language used to describe health conditions can affect attitudes and stigma towards people with that health condition, particularly those with addictions.1 If necessary, we have edited the discussion notes to use person-first and non-stigmatizing language.2

Workshop overview

The workshop was developed based on the format and experience of the Health Promotion Capacity Building team at PHO in delivering capacity building workshops on situational assessments and program planning.

Workshop planning

The core planning team for the workshop consisted of two PHO staff and one trainee, including a Public Health Physician, Health Promotion Consultant, Public Health and Preventive Medicine Resident, with support from the Chief of Health Promotion, Chronic Disease and Injury Prevention (HPCDIP) at PHO. We also held two planning meetings with workshop panelists, and five individual discussions with practitioners in Ontario to inform the content and format. Additionally, registered participants completed a five-question web-based needs assessment questionnaire prior to the workshop to tailor the agenda further to local needs.

Workshop format

The workshop was a mixture of presentations and small and large group discussions. Presentations included brief background information on opioid use and related harms, engaging people with lived experience, situational assessment, and evidence-informed decision-making. In small groups, participants discussed barriers and facilitators for evidence-gathering and completed a SWOT analysis (strengths, weaknesses, opportunities, threats) of areas of potential action. Further, attendees heard from three panelists from diverse perspectives involved in the development of plans to address opioid-related harms. (See Appendix A for the workshop agenda).

Morning session: Evidence gathering

Opioids in Ontario

Opioid prescribing has increased in Ontario over the past two decades[3], with an increase in the number of people dispensed an opioid of 1.5% between 2013/14 to 2014/15, representing over 28,000 additional recipients.[4] In 2015/16 one in every seven people (14 per cent) received an opioid prescription, with over nine million prescriptions filled.[5] In parallel, opioid-related harms in the Ontario population have continued to rise between 2003 to 2016, including emergency department visits, hospitalizations, and deaths.[6] Together, these outcomes represent a large burden of opioid-related morbidity and mortality, as well as health care costs.

Comprehensive strategies to address opioid-related harms are developing in many jurisdictions, including at local and provincial levels in Ontario. Many drug strategies follow a "four pillar" approach, addressing prevention, treatment, harm reduction, and enforcement, as reflected in The New Canadian Drugs and Substances Strategy.[7] Using systematic methods for situational assessment and health promotion program planning can strengthen these plans and ensure they are tailored to the local context. Please see Appendix B for a copy of the presentation slides.

Engaging people with lived experience

Matt Johnson, Harm Reduction Coordinator at Queen West Toronto Community Health Centre, gave a presentation on meaningful involvement of people with lived experience in program planning and implementation, entitled "Nothing About Us Without Us." The presentation covered key aspects of engaging people who use drugs (PWUD) on strategies to reduce opioid-related harms, including reasons to involve PWUD, recruitment strategies, tips to ensure success in engagement, and successfully including the voices of PWUD in opioid action plans. For a copy of the presentation slides with details on these areas, please see Appendix B.

Conducting a situational assessment

An important and necessary step in planning is carrying out a situational assessment. Situational assessment is a mandated activity for local public health units through the Ontario Public Health Standards.[8] "A situational assessment is a systematic process to gather, analyze, synthesize and communicate data to inform planning decisions."[9(p. 1)]

PHO uses a six-step process model for how to carry out a situational assessment:

- Step 1: Identify key questions to be answered
- Step 2: Develop a data-gathering plan
- Step 3: Gather the data
- Step 4: Organize, synthesize and summarize the data
- Step 5: Communicate the information
- Step 6: Consider how to proceed with planning[9]

Situational assessments answer three main questions:

1. What is the situation?
2. What influences are making the situation better and worse?
3. What possible actions can you take to address the situation?

By answering these questions, situational assessments provide the information needed to determine goals, objectives, priority populations and target audiences, and activities for a program using an evidence-informed decision-making process.[9]

For the workshop slides please see Appendix B. For a more detailed description of how to complete a situational assessment, please see Focus On: Six strategic steps for situational assessment. For a more detailed description of the six steps involved in planning a program, please see Planning health promotion programs: introductory workbook.

Evidence gathering — a practical exercise

The larger group was divided into six facilitated group discussions. The group discussions were focused on the three key situational assessment questions (broken into three question sets, including sub-questions) for evidence gathering. The groups were provided some underlying sub-questions to the three key questions as well as examples for discussion. Two groups initially discussed each question set, and then the facilitators rotated to the remaining two groups for further input on considerations for data gathering for the particular focus question. The three key question sets, with most of the sub-questions can be found in table A below.

Participants were asked to share existing data sources, additional data that would need to be collected, as well as perceived facilitators and barriers. See Appendix C for a complete list of possible key questions for a situational assessment on opioid-related harms and examples provided. Appendix D provides the combined results for each key question group with duplicated results removed.

TABLE A: SUMMARY OF SITUATIONAL ASSESSMENT QUESTIONS FOR EVIDENCE GATHERING

Question set	Key questions and sub-questions
A	**What is the situation?** • What impact does the current opioid situation have on health outcomes, quality of life and other societal costs? • Which groups of people are at higher risk of health problems and poorer quality of life? • Which settings or situations are high risk, or pose a unique opportunity for intervention?
B	**What is the situation?** • How do local stakeholders perceive the situation? What is their capacity to act? What are their interests, mandates, current activities? • What are the needs, perceptions and supported directions of key influential community members, and the community-at-large? **What possible actions can you take to address the situation?** • What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community?
C	**What influences are making the situation better and worse?** • What high-risk or negative **health behaviours** by various groups of people are affecting the situation? • Which **underlying causes or conditions** are driving these behaviours (e.g., individual, community, organizational or system-level causes)? • Are there **protective factors** that can help avoid or alleviate the situation?

Afternoon session: Action planning and community engagement

Evidence-informed decision making

Research evidence is another important source of evidence to answer the third key question in situational assessment: what possible actions can you take to address the situation? Using research evidence aligns with another core competency for public health practice: Evidence-Informed Decision Making (EIDM).[8] EIDM is "the process of distilling and disseminating the best available evidence from research, context and experience, and using that evidence to inform and improve public health practice and policy."[10] The National Collaborating Centre for Methods and Tools (NCCMT) provides a model for EIDM which includes four domains of evidence:

i. Community health issues, local context

ii. Community and political preferences and actions

iii. Research evidence

iv. Public health resources to use in decision making.

NCCMT developed a seven-step process to guide the search for and synthesis of research evidence which can be used when answering the third key question in situational assessments. The EIDM process developed by NCCMT is best used *after* you have determined a program's goals, objectives, and priority populations.

Panel experiences

Claire Farella, Manager, Healthy Living and Development at Leeds, Grenville and Lanark District Health Unit, Vera Etches, Deputy Medical Officer of Health at Ottawa Public Health and Ariella Zbar, Associate Medical Officer of Health at Sudbury & District Health shared their experiences with planning to address opioid-related harms. The panelists shared their health unit's current priorities, highlights of the development process, and commented on their perceived successes and challenges. Please see Appendix E for more details on these presentations.

SWOT discussion

A common tool that comes from the business world and now used in planning across many sectors is SWOT. SWOT stands for strengths, weaknesses, opportunities and threats. An analysis of SWOT permits organizations to identify assets which can be strengthened, internal and external barriers which may arise, as well as external opportunities to leverage during the design and implementation of a program. Strengths and weaknesses are internal to an organization and opportunities and threats are external to an organization. The larger group was divided into six smaller groups for facilitated SWOT discussion as it relates to participants' own organizations or Public Health in general. Four groups focused on one of the four pillars of a drug strategy discussed above. The two remaining groups focused on communicating with the public and community engagement. These two topics were chosen as they were themes discussed throughout the day. Please see Appendix F for point-form summaries of each of these discussions.

Conclusions

Situational assessment is a core skill in public health practice. This meeting reviewed the key steps in situational assessment, and further developed skills in their application to a specific topic. The collective thought and experiences of workshop attendees on how to apply these essential skills to opioid-related harms are reflected in the appendices of this report. These summaries can be used by public health units across Ontario to inform practice to address opioid-related harms at the local level.

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Appendix A: Agenda

Applying Situational Assessment Skills to Address Opioid-Related Harms

May 9, 2017 - 9am- 4pm

480 University Avenue, Room 345

The objectives of the workshop are:

1. Increase knowledge and skills in conducting situational assessments

2. Consider how to apply situational assessment skills to the issue of opioid-related harms

3. Identify key considerations in undertaking and gathering information for a situational assessment to inform program planning to address opioid-related harms

Time	Activity	Objective(s)	Presenter(s)/ Facilitator
9:00-9:30	Welcome and orientation Presentation: Opioid context Presentation: Lived experience	Orientation of audience and background information Provide overview of agenda Set the context for the day	Heather Manson Pamela Leece Matt Johnson
9:30-10:00	Presentation: Intro to Situational Assessment, Health Promotion Planning, OPHS revised standards Presentation: Key questions for data collection	Introduce situational assessment Introduce process of developing key questions	Allison Meserve
10:00:10:30	Small group work: Data collection discussion 6 tables, 1 PHO facilitator at each table 3 key questions to be discussed by each table (45 minutes)	Discussion on data re: Sources, Methods of collection, Facilitators/ Barriers, Tools	Allison, Pam, Stacie Carey, Rabia Bana, Richard Bochenek and Karin Hohenadel
10:30-10:45	BREAK		
10:45-11:15	Continued group discussions		

Time	Activity	Objective(s)	Presenter(s)/ Facilitator
11:30-12:00	Review of data gathering discussions: Group members provide feedback/additions (10 minutes)	Getting feedback on the data gathering approaches identified	Allison, Pam, Stacie, Rabia, Richard and Karin
12:00-1:00	LUNCH		
1:00-1:30	Presentation: EIDM	Situate EIDM in program planning steps	Allison
1:30-2:30	Panel discussion and Q&A on Opioid Action Plans focusing on: Planning process used Priorities identified Barriers and facilitators to planning	Learn from experiences of PHUs who have begun addressing opioid-related harms	Pam and Allison
2:30-3:30	Small group discussion: SWOT analysis at organizational level Synthesis of SWOT	Understand organizational barriers/facilitators for implementation; stakeholders	Allison, Pam, Stacie, Rabia, Richard and Karin
3:30-4:00	Wrap up Next steps Facilitated large group discussion around the 3 key questions listed	What have we learned? How will we act on what we learned? Plan dissemination of results	Allison and Pam

Appendix B: Presentations

The following presentation slides are included:

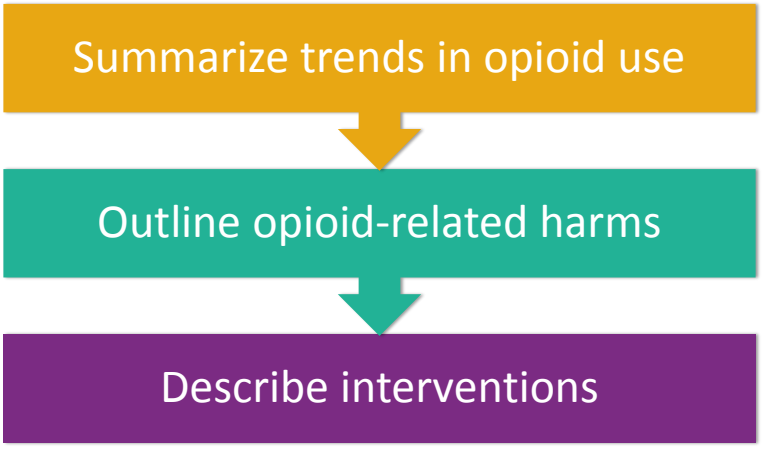
- Understanding the opioid crisis: A public health perspective. Presented by Dr. Pamela Leece, Public Health Physician, Health Promotion, Chronic Disease and Injury Prevention at Public Health Ontario.
- Nothing about us without us. Presented by Matt Johnson, Harm Reduction Coordinator at Queen West Toronto Community Health Centre.
- Applying situational assessment skills to address opioid-related harms. Presented by the Health Promotion Capacity Building Team at Public Health Ontario
- All presenters provided consent to have their presentations published as part of this report.

Understanding the opioid crisis in Canada: A public health perspective

Dr. Pamela Leece, Public Health Ontario

Situational Assessment Workshop
May 9, 2017

Agenda



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Opioid Use in Canada

Ontario Agency for Health Protection and Promotion | Agence de protection et de promotion de la santé

Public Health Ontario | Santé publique Ontario

Opioid use: what is an opioid?

- Substance with a effects similar to opium (pain relief, sedation)
- Act on the body's opioid receptors
- Used as strong pain reliever
- Little evidence of long-term benefit outweighing harms
- Serious warnings: addiction, life-threatening respiratory depression, accidental exposure, neonatal complications

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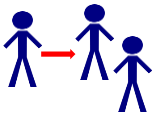
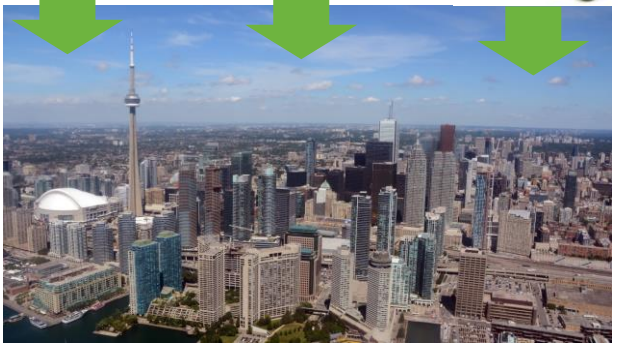
Opioid use: availability

Uncontrolled
- Illegal manufacturing
- Counterfeit pills

Prescribing
- Often unsafe
- Diversion





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Opioid use in Ontario

Monitored drug category[2]	2014/15		
	Dispense events	Recipients	Prescribers
Injectable mixtures	17,629	4,045	1,457
Barbiturates	104,785	13,723	5,616
Cannabinoids	183,766	20,138	6,641
Androgens	193,438	45,785	9,345
Stimulants	1,275,857	148,158	16,646
Benzodiazepines	6,228,235	910,315	34,166
Opioids[3]	8,961,929	1,956,004	43,572
Methadone maintenance treatment (MMT)	11,443,952	41,837	960
Suboxone and generics	999,420	11,245	1,333

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Ontario. Ministry of Health and Long-Term Care. Ontario narcotics atlas. Toronto, ON: Queen's Printer for Ontario; 2016. Available from: http://www.hpepublichealth.ca/sites/default/files/ON%20Narcotics%20Atlas%20FINAL%20%28December%202016%29.pdf

Opioid use: non-prescription

- **According to RCMP:**
  - Last 12 months: increased fentanyl presence
  - China continues to be the pivotal source
  - Opioids are now preferred substitutes or supplements for other illicit drugs (e.g., heroin, cocaine)
  - **Dosage variability amongst illegal powders or tablets**
    - **Significantly raises the risk of overdose and death**
- **Carfentanil: Ontario Poison Centre**
  - Has properties that are not characterized in humans
  - Universal precautions should be followed as per usual
  - No reports of rescuers overdosing from accidental exposure

Royal Canadian Mounted Police. Fentanyl and beyond: evolutions in the Canadian illicit opioid market. Ottawa, ON: Her Majesty the Queen in Right of Canada; 2016.

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Opioid-related harms

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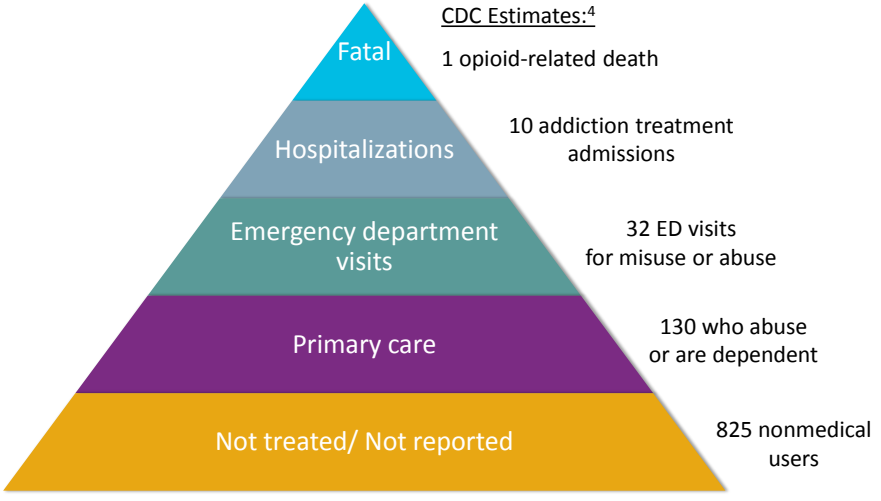
Opioid Injury Pyramid



Injury pyramid adapted from: World Health Organization. Injuries and violence: the facts 2014. Geneva: World Health Organization; 2014. Available from: http://apps.who.int/iris/bitstream/10665/149798/1/9789241508018_eng.pdf?ua=1&ua=1&ua=1

Figure 1: Trends in Opioid-Related Deaths by Year and Age Groups in Ontario, 1991 to 2015

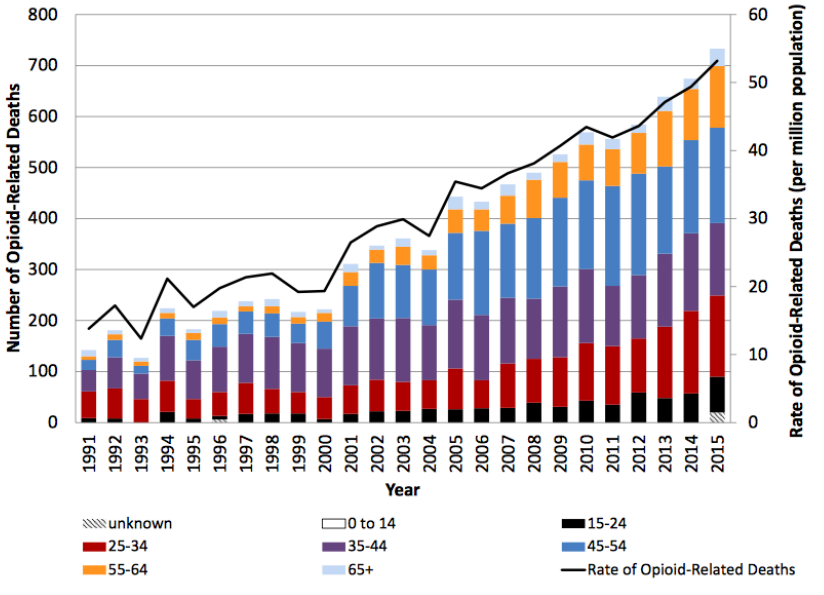


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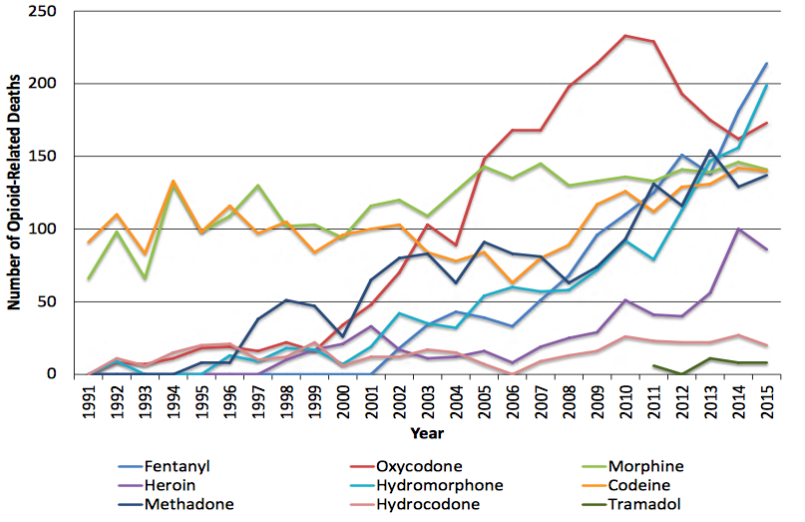
Figure 2: Trend in Opioid-Related Deaths in Ontario by Type of Opioid Involved, 1991 to 2015



Note: 20 deaths from 2015 where details on specific opioid involvement was unavailable are not reported in this figure.

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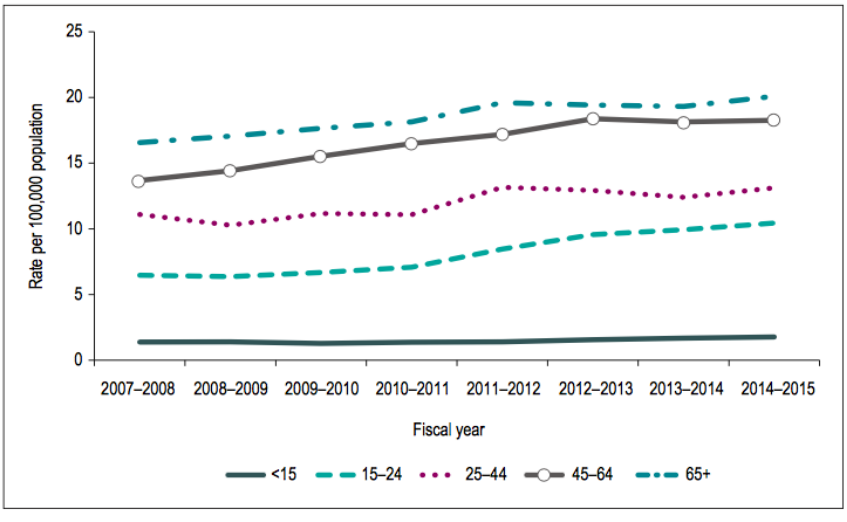
Gomes T, Greaves S, Martins D, Bandola B, Tadrous M, Singh S, et al. Latest trends in opioid-related deaths in Ontario: 1991-2015 [Internet]. Toronto, ON: Ontario Drug Policy Research Network; 2017 [cited 2017 Oct 13]. Available from: http://odprn.ca/wp-content/uploads/2017/04/ODPRN-Report_Latest-trends-in-opioid-related-deaths.pdf

Figure 3 Rate of hospitalizations due to opioid poisoning per 100,000 population by age group, Canada, 2007–2008 to 2014–2015



Source
Hospital Morbidity Database, Canadian Institute for Health Information.

Direct links: Prescribing and Harms

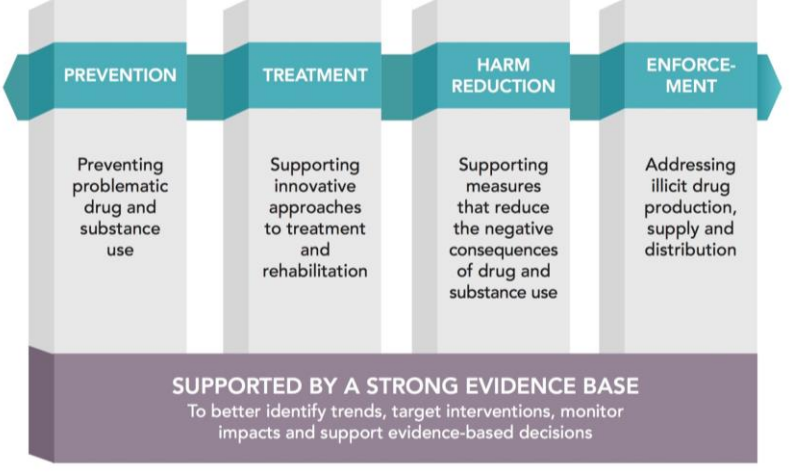
82%	• Prescribed opioids in the year before opioid-related death (Dhalla 2009) • 56% in month before opioid-related death
59%	• First exposed by prescribing – among those with heroin or nonmedical prescription opioid use (Butler 2016)
5.5%	• Develop addiction in chronic opioid therapy (Jason W. Busse, McMaster University – personal communication)
3x	• Risk of opioid-related mortality on morphine equivalent dose 200mg/d vs. <20mg/d (Gomes 2011)

How did we get here?

Photo sources: 1) CBC.ca 2) http://chirolongevity.com/services/chiropractic/pain.html 3) http://medicine.dundee.ac.uk/medical-education-centre/centre-medical-education 4) http://m.inmagine.com/image-is098r9gw-Man-with-hand-over-face.html

Intervention approaches

Four pillars



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Environmental scan of approaches

Education: Prescribing guidelines

Best practices guidelines ≠ improved care	• Need effective implementation strategies • http://www.cfp.ca/content/59/5/e231.short
Self-regulation	• Limited information on and management of physician performance
Physician education limited	• Chronic pain, addictions, and mental health

Health services and harm reduction

- Needle exchange programs
- Supervised consumption services
- Medication-assisted treatment
- Naloxone

Future Directions?

Novel Approaches in Recent Literature

- Recovery Coaches after Non-fatal Overdose
- Public Health Opioid Detailing in Primary Care
- Community Walking Programs for Arthritis Pain Management
- Opioid Fatality Review Teams

Key Messages

The problem of opioid-related harms in Canada is

- BIG
- Complex
- Worsening

The solutions need to be

- Comprehensive
- Timely
- Evaluated

Public health practitioners and community partners have excellent skills to be part of the solution!

Thank you!

- Questions?

Nothing About Us Without Us

Meaningful involvement of people with lived experience in program planning and implementation

Matt Johnson, Harm Reduction Coordinator at Queen West Toronto Community Health Centre

Why involve PWUD?

- Increased access to marginalized people and communities
- Increased buy in and trust building with marginalized communities
- Up to date information about trends, issues and concerns in local community
- Increased relevance and helpfulness of programming
- Unique ideas on how to address health issues, as well as what issues should be addressed
- Less chance of inadvertently creating harms in communities

Recruitment

- Information sessions with free meals
- Outreach
- Identifying strong voices in community and tapping them to recruit others
- Identifying the faces seen daily and approaching them
- Partnerships with other agencies
- Reassuring PWUD of safety and, when necessary, anonymity
- Once peer programs are set up, PWUD in your program become the greatest recruitment tool

Ensuring success

- Adequate pay (Payroll vs. Honoraria)
- Food
- Extra Support (Who will their support person be? Should supervisor be support person also? How do they get support from each other?)
- Different expectations of professionalism, different rules than salaried staff
- CLEAR expectations about rules, professionalism, behaviour, responsibilities
- The opportunity to make mistakes, and use them as learning moments

Including the voices of PWUD

- PWUD need to be front and center. Their voices should be heard first not last
- Involve PWUD in all stages of program planning and from planning into implementation
- 'Greater' and 'meaningful' involvement of PWUD
- Be prepared to hear feedback that may be surprising or does not align with what you want to hear
- Use direct quotes where possible. Often the voices or PWUD are censored and filtered
- Provide mentoring and training to help people become more involved in program planning and agency activities

Applying Situational Assessment Skills to Address Opioid-Related Harms

Health Promotion Capacity Building, HPCDIP

May 2017

Ontario Agency for Health Protection and Promotion / Agence de protection et de promotion de la santé

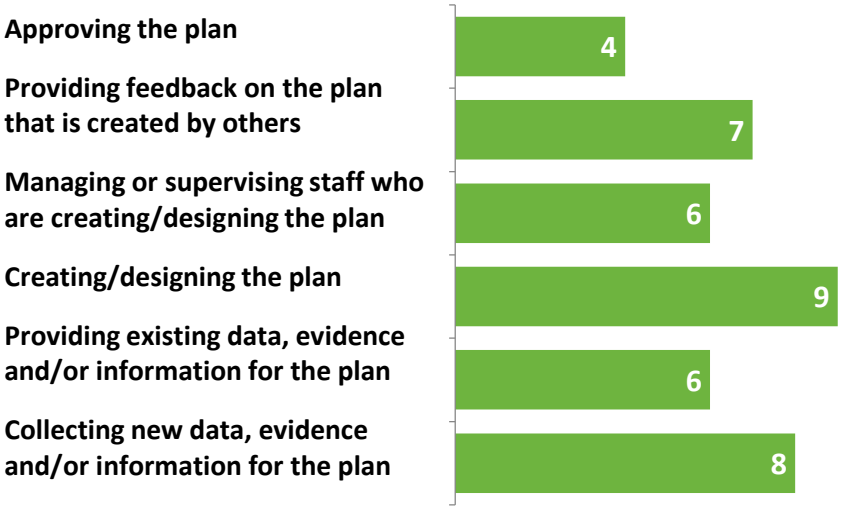
V 1.3

Public Health Ontario / Santé publique Ontario

Learning Needs Assessment Results

- 17 people responded
  - 14 are beginners or have some idea of the concepts
- Organizations are in various stages of planning
  - 3 people have not begun or are in the pre-planning stage
  - 13 have begun planning
  - 1 has an approved plan

Role in the situational assessment



Challenges (anticipated or experienced)

- Timeliness of data
- Identifying populations affected
- Multiple stakeholders
- Differing perspectives on the problem…and the right solution(s)
- Reporting data to decision makers and influencers
- Resources

Hopes and dreams (for the workshop)

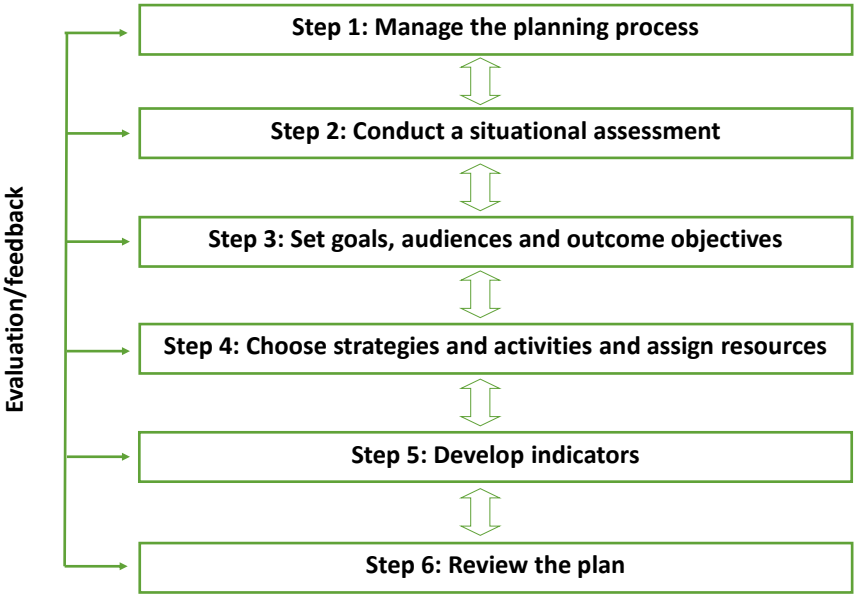
- Methodological steps
- Increased knowledge of the issue
- Strategies for working with community partners
- Learning from other PHUs

Learning Objectives

- Increase knowledge and skills in conducting situational assessments
- Consider how to apply situational assessment skills to the issue of opioid-related harms
- Identify key considerations in undertaking and gathering information for a situational assessment to inform program planning to address opioid-related harms

Situational Assessment

The **6** steps to planning a health promotion program[1]



Six steps for conducting a situational assessment[2]

Step 1: Identify key questions to be answered

⇩

Step 2: Develop a data gathering plan

⇩

Step 3: Gather the data

⇩

Step 4: Organize, synthesize and summarize the data

⇩

Step 5: Communicate the information

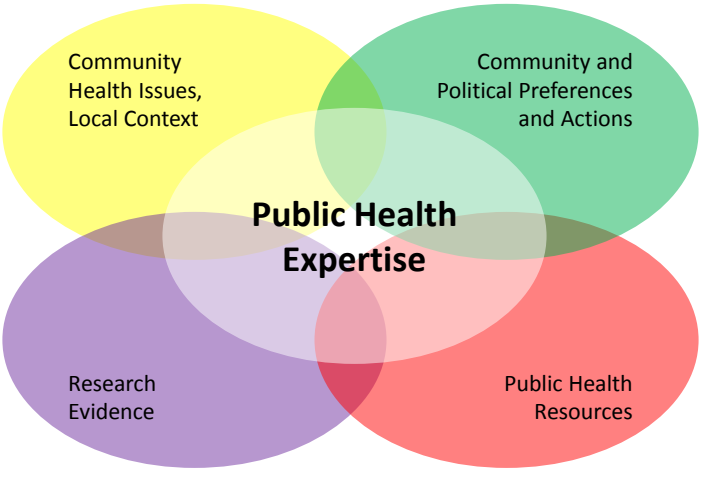
⇩

Step 6: Consider how to proceed with planning

What is evidence?

Information or facts from a variety of both qualitative and quantitative sources, “that are systematically obtained (i.e., obtained in a manner that is replicable, observable, credible, verifiable, or basically supportable).” [4(p. 52)]

Model of EIDM in Public Health[3]



Step 1: Identify key questions to be answered

1. What is the situation?
2. What is making the situation better and what is making it worse?
3. What possible solutions, interventions and actions can you take to deal with the situation?[2]

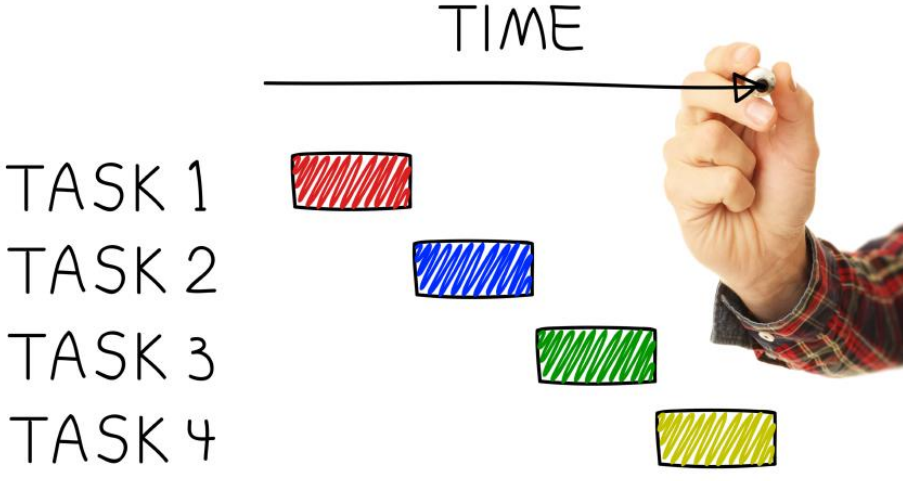
Step 1: Identify key questions to be answered

- Surveillance
- Causation
- Experience
- Intervention[6]

Key Question Examples

- Which groups of people are at higher risk of health problems and poorer quality of life?
- What are the needs, perceptions and supported directions of key decision makers (e.g., elected officials, civil servants, healthcare CEOs) and influencers (e.g., citizens, advocacy groups, community organizations, business improvement areas)?
- What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community?

Step 2: Develop a data-gathering plan



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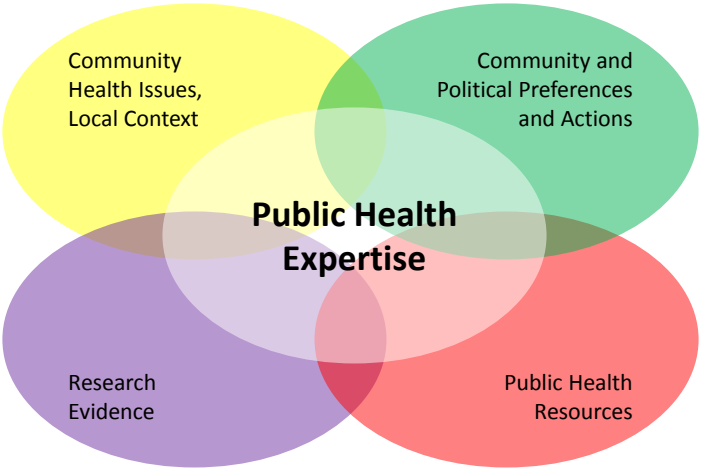

Discussion Questions

1. What data already exist?
2. What data/information do you need to collect?
3. What are some of the barriers/facilitators to obtaining/collecting these data?

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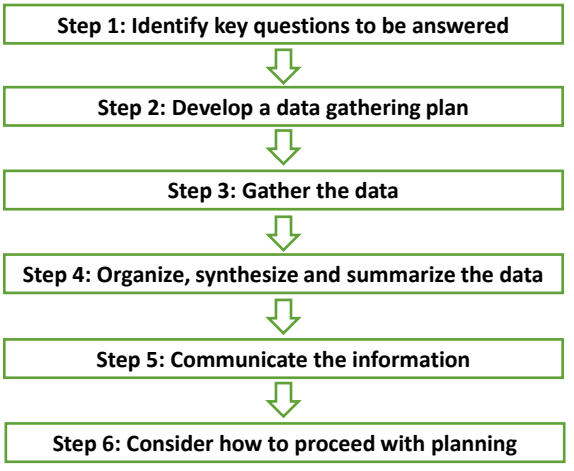
Six steps for conducting a situational assessment[2]



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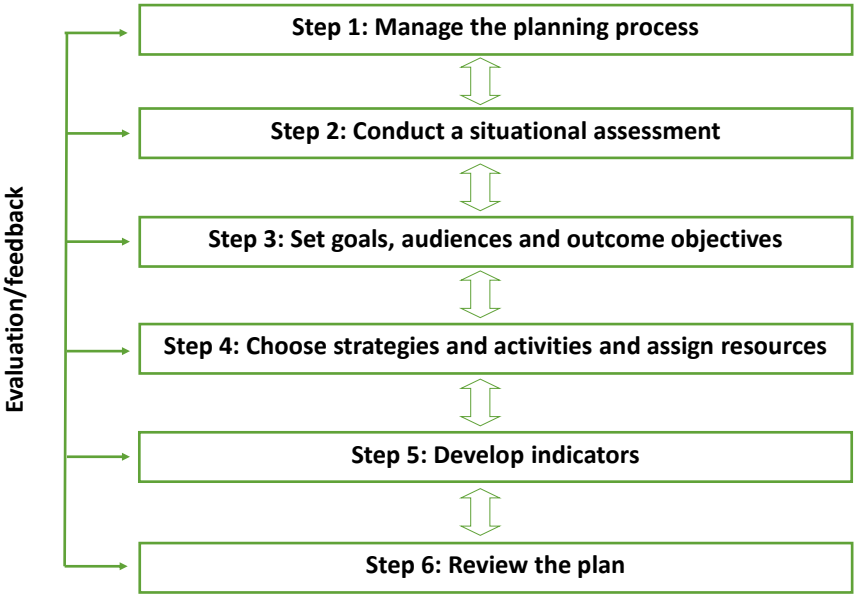
The **6** steps to planning a health promotion program[1]



SWOT Analysis

Factor	Example
Strength	Credibility of your organization with funders
Weakness	Internal accountability mechanisms make it very hard to work in partnership with other organizations
Opportunity	There is a new granting program of the provincial government relating to your program issue
Threat	Your local council has twice refused to fund a program of this kind

Step 5: Communicate the information

Step 5: Communicate the information

- Target audience (Primary and secondary)
- Objective
- Key messages
- Strategy
- Tactics

Step 6: Consider how to proceed with planning

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Thank you!

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Content for this workshop was adapted from the Online Health Promotion Planner available at: www.publichealthontario.ca/OHPP

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Appendix C: Key questions for situational assessments for opioid-related harms

Situational assessments are answering three key questions:

1. What is the situation?
2. What influences are making the situation better and worse?
3. What possible actions can you take to address the situation?[9]

Sub-questions to the three key were generated by the planning committee and can be found below. These questions can be used to gather necessary evidence to inform planning decisions.

1. What is the situation?

a. What **impact** does the current opioid situation have on health outcomes, quality of life and other societal costs? For example:

- ED visits
- EMS calls
- Hospital admission
- Use of addiction treatment services and non-urgent medical services
- Neonatal abstinence syndrome
- Motor vehicle collisions
- Incarceration
- Police calls
- Death (accidental versus suicide)
- Child protection cases
- Intergenerational impacts/ adverse childhood events

b. Which groups of people are at higher risk of health problems and poorer quality of life? For example:

- Certain age groups (including youth, seniors, 35-44)
- Males
- Income quintile
- Those with mental health issues
- Those with substance use disorder
- Those suffering chronic pain
- Incarcerated individuals
- Individuals using injection drugs
- Those with previous non-fatal overdose

c. Which settings or situations are high risk, or pose a unique opportunity for intervention? For example:

- Shelter
- Emergency department
- Addiction services
- Jails and prisons
- Schools
- Primary care

d. How do local stakeholders perceive the situation? What is their capacity to act? What are their interests, mandates, current activities? For example:

- Health care
- Social service
- Education
- Enforcement
- Political
- Harm reduction

e. What are the needs, perceptions and supported directions of key influential community members, and the community-at-large? For example:

- Community and political leader's attitudes towards harm reduction services
- Community and political leader's attitudes regarding location of treatment and harm reduction sites
- Community and political leader's opinions regarding drugs, drug use, and addictions
- Physician attitudes regarding opioid prescribing
- Provincial and national medical care policies
- Provincial and national drug strategy policies

2. What influences are making the situation better and worse?

a. What high-risk or negative health behaviours by various groups of people are affecting the situation? For example:

- Pain management
- Diversion of medications
- Non-medical substance use
- Injection use
- Co-administration of multiple substances

b. Which underlying causes or conditions are driving these behaviours (e.g. individual, community, organizational or system-level causes)? For example:

- Individual: e.g., poverty, adverse childhood events, mental health, experimentation
- Community: e.g., social attitudes

- Organizational: e.g., health services for pain, addiction, mental health
- System-level: e.g., drug policies, health services/treatment policies

c. Are there protective factors that can help avoid or alleviate the situation? For example:

- Individual: e.g., resilience
- Community: e.g., community supports
- Organizational: e.g., health services – accessible, timely, evidence-based
- System-level: e.g., health-based approach to drug use

d. Which strengths and weaknesses present in your organization may affect your course of action? Which opportunities and threats in your environment may affect your course of action?

3. What possible actions can you take to address the situation?

a. What are other organizations doing, or what have they done in the past, to address this situation? Specifically, what local policies, programs and environmental supports are being developed or implemented within the community? What evaluation data are available for these activities? For example:

- Prevention
- Treatment
- Harm reduction
- Education
- Surveillance/research
- Enforcement

b. What is the best-available evidence that exists to support various courses of action?

Appendix D: Evidence-gathering activity

Step 2 in conducting a situational assessment is to create a data gathering plan. The data gathering plan often includes both existing data and data that need to be collected.[9] In order to brainstorm possible data sources for each of the three key questions and sub-questions (see Appendix C) the larger group was divided into six facilitated group discussions. The group discussions were focused on the three key situational assessment questions (broken into three question sets, including sub-questions) for evidence gathering. The groups were provided some underlying sub-questions to the three key questions as well as examples for discussion. Two groups initially discussed each question set, and then the facilitators rotated to two additional groups for further input on considerations for data gathering. As each question set was discussed by two groups, we have combined the notes and removed duplicates. Where the notes would not be clear to someone who was not in attendance, the facilitators have added additional explanation in brackets.

Question set A

KEY QUESTION: WHAT IS THE SITUATION?

1a. What impact does the current opioid situation have on health outcomes, quality of life and other societal cost?
1b. Which groups of people are at higher risk of health problems and poorer quality of life?
1c. Which settings or situations are high risk, or pose a unique opportunity for intervention?

Existing data	Data needs[1]	Facilitators	Barriers
Death data (vital stats/coroner) Scene reporting from police Emergency department triage data ACES Direct reporting from EDs "NACRS II" (weekly collection of ED data) RRFSS Naloxone administration and distribution [including Public Health] NEP data [including mobile] OATC urine sample data iPHIS Community reports of overdoses Includes crowd sourcing NACRS, DAD EDI	How many opioid users are there How many opioid related overdoses are there Fatal Non-fatal Co-substance use Withdrawal and treatment Substitution therapies Wait lists Type of opioid users Prescription Non-prescription (diverted or street) Inadvertent/ accidental Stratifiers: Age Sex Geography (urban/rural) LGBT SES	Political [will and] preference [for intervention types] (can be good or bad) Community [interest and] preference [for intervention types] Media Good relationships Cross-ministry cooperation (Health, Education, Corrections) [Regular] Meetings/networks [Sense of] urgency "Allies in odd places" [may have common interests with new partners, e.g., parks department, BIA] Risk assessment [having data contributes to risk assessment, and that assessment can help make the case for better access to	Stigma Credibility Timeliness Using data sources that are not intended for surveillance Privacy Information sharing Not reportable Using proxies Media Resources Silos/doing things differently "Myths" "optics" "perceptions" [about which opioids are involved – everyone thinks fentanyl and this may not be the case] Coordination Use of data [is it in a format that is accessible/available and usable? Are we allowed re:

[1] One of the groups also had a discussion on "what not to collect" – data collection can "open a can of worms" and should not be collected if we may not have supports to address these issues (e.g., asking patients about trauma)

Existing data	Data needs[1]	Facilitators	Barriers
OSDUHS	Ethnicity	data]	privacy?]
Area-based SES measures e.g. Ontario Marginalization Index (ON-Marg)	Aboriginal status	Triangulation [of multiple data sources]	Clear objectives/triggers
Census	Education		Quality/reliability
9-1-1 calls	Place of incident		Criminalization
EMS	Societal impacts		Alert fatigue [people see alerts all the time about bad drugs and stop paying attention]
Police	Impact on individuals, families, children		[Not knowing] baseline rates
Community forum [may not cover all areas of the community; could be linked to drug strategy or "situation table"]	Upstream determinants		Dispersed [events may be dispersed, e.g., different hospitals, so do not detect a cluster]
Laboratory data (some)	Housing, supportive housing services available		Roles [not knowing roles in the collection/use of data]
Treatment facilities/OATC	Untreated mental illness		Change [management – changing systems of data collection and reporting]
Meetings with partners [anecdotal information]	Co-morbidities		How to use or coordinate data
Drug seizure data [Health Canada labs]	Prescription patterns		
Community services [use or reports of events]	Novel analogues [Fentanyl analogues and other NPS]		
Anecdotal	Children's aid		
Media reports [may not be reliable]	Early childhood supports		
	Naloxone intervention information [administrative data]		
	Including pharmacies/schools		
	Detailed data from methadone clinics		
	Police data		
	Schools		

Existing data	Data needs[1]	Facilitators	Barriers
	Imports[what drugs are being imported illegally]		
	Dental prescriptions		
	Laboratory data		
	Infections related to drug use		
	Electronic medical records [e.g., primary care]		
	[Additional information for specific settings including]		
	Shelters “sentinel” [shelters can be sentinel sites where we may detect worst-case scenarios first]		
	Harm reduction		
	Corrections		
	Hospital/health care		
	Treatment facilities/programs		
	School		
	Discharge [discussion that people may be protected when in these settings but higher risk when discharged]		

Question set B

KEY QUESTION: WHAT IS THE SITUATION?

2a. How do local stakeholders perceive the situation? What is their capacity to act? What are their interests, mandates, current activities?

2b. What are the needs, perceptions and supported directions of key influential community members, and the community-at-large? Key question: What possible actions can you take to address the situation?

2c. What are other organizations doing, or what have they done in the past, to address this situation?

Existing data	Data needs	Facilitators	Barriers
Qualitative data (local addiction centres, any data from users)[some PHUs and organizations working with PWUD have existing survey and interview data in relation to perceptions to the issue]	Political data (can we learn more about their perspective? Conversations with the public?)	Community interest and motivation	Data sharing agreements with community partners, challenge to get them in place
Community drug surveys (certain communities may have)	List of available resources within healthcare	Provincial strategy	Once agreements are in place, another challenge related to what to do with data? How does public health share? With whom? In what format?
School board data (e.g., interviews)	Treatment programs	Support from CMOH	Agency mandates and limitations
Media (reports, articles) [review of media articles for perceptions towards the issue]	Beds capacity	Grants available (e.g., Trillium grants)	Credible, reliable and timely data
Pre-existing networks in the community	Community attitudes	Information sharing across PHUs	Indicators are not well defined
GIS data	Gather information on all existing programs – central information repository	Use the 4 pillar drug strategy as a way to organize	Small sample sizes in small communities, and how to act/prioritize
	Standardized data collection	Opioid surveillance tool	Data often relates to overdose
	Coordinate data on naloxone kit distribution	Recognize low-hanging fruit, areas for action	
	Evaluative data of naloxone kit distribution:	Existing networks and facilitate connections (don't assume they know each other)	

Existing data	Data needs	Facilitators	Barriers
Opportunity to collect data from 'dealers' (Queen West Centre has considered the potential of this for their own use, but obviously could not share)	How much is actually administered to how many patients? Is it being stockpiled; how much and by whom? Recovery from overdose Is this new or a repeat event: how many times? Discharged to home or elsewhere? Follow-up on the NACRS Evaluation of treatment services outcomes e.g.: Abstinence x 1 yr; Decreased use x 2 yr; Family support	Public Health has clear lead in harm reduction strategies Federal/Provincial/Territorial support – some resources are coming online Public Health has a solid history of connecting with this vulnerable population	and response - there are other areas for public health to act on, but the overdose data makes it a priority Police as a partner in the response – can be a difficult relationship especially trying to engage harm reduction partners or those with lived experience, all at the same table, lack of trust Criminalization, can lead to concealing/hiding/not open to sharing information that could be helpful Political context and will, identifying champions

Question set C

KEY QUESTION: WHAT INFLUENCES ARE MAKING THE SITUATION BETTER AND WORSE?

3a. What high-risk or negative health behaviours by various groups of people are affecting the situation?

3b. Which underlying causes or conditions are driving these behaviours (e.g. individual, community, organizational or system-level causes)?

3c. Are there protective factors that can help avoid or alleviate the situation?

Existing data	Data needs	Facilitators	Barriers
Canadian Community Health Survey	Prescription data (narcotics) [more timely and better access]	Partnerships with police, EMS, other PHUs	Many people don't respond to substance use questions on surveys
Coroner's data	Local data for overdose, hospitalizations, etc.	Political will	Getting local data is difficult
NEP statistics	Primary care [healthcare utilization, diagnoses, reasons for visits, prescribing patterns]	Cross-Ministry cooperation	Privacy legislation is a barrier to linking data and to identifying high prescribers
Anecdotal data from clients	Local SDOH data	Data sharing among stakeholders	Hospital data too general
NACRS	Evidence review on protective factors	Identifying now what data will be needed in the future	Time lag for Coroner's data
ED data	Data at school level-upstream information for prevention	Existing relationships	Lack of reliable, rapid test to identify narcotics being used
Acute Care Enhanced Surveillance	Youth surveys [e.g. OSDUHS]	Champions	Legislative environment/cultural "prohibitionists"
Narcotics prescribing data	Linkages between various data sources		Stigma (intention bias towards extreme cases and groups) [We tend to focus on the extreme cases when planning responses, and don't necessarily look at moderate cases. So we are better at
Social surveys-income, employment (Statistics Canada)	Data on intent and type of use		
Community well-being surveys (local)			
Primary care data [accessible to those within the practice]			

Existing data	Data needs	Facilitators	Barriers
Housing stats	Childhood trauma		identifying risk factors and severe outcomes, than protective factors.]
Point of contact SDOH collection (e.g. Toronto Central LHIN)	Tracking upstream risk factors (e.g. family history) (possibly from addiction services)		Lack of system coordination; different data sources are not linked; costly to do so
Mental health stats [from CCHS, CIHI, Toronto Central LHIN]	Community partners [people they serve (numbers, geographically), types of services provided, areas of need/support, high risk areas/populations]		Lack of cross-Ministry cooperation
Ontario Narcotics Atlas			Narcotic atlas only ODB-eligible individuals
Community housing			Timeliness of data
Narcotics monitoring system	Those affected [lived experience, concerns, needs]		Accessibility/usability of partner data
Local NEP administrative data	Stakeholder consultations		Privacy with data sharing
Naloxone service providers administrative data	Meetings with decision makers [transparency and access to what is discussed; how policy decisions are made and who is involved]		In rural/remote areas, there is often a small number of individuals affected, making it difficult to share, understand trends, etc.
Police			Differences in the way municipal provincial police collect and report
EMS/Paramedic data	Environmental scan of existing services and capacity including:		Police – how crimes are classified when opioids are involved
iTRACK	Resiliency programs		Stigma
WSIB data	Pain management		Shared language and definitions
Regional prescription rates	Parenting groups		Mandate
Existing literature on provider KAP			Research funding priorities
Existing policies and laws regarding drugs			

Appendix E: Panel experiences

Three health unit staff spoke to their organizations' experiences thus far addressing opioid-related harms. Presenters provided us with permission to include the slides below or reviewed and approved the summary of their presentation.

Dr. Ariella Zbar, Associate Medical Officer of Health, Sudbury & District Health Unit

Panel presentation summary

Priorities

- Proposed local opioid action plan includes areas such as: data needed to inform action (ex. downstream and upstream indicators of opioid use and opioid-related harms), translating data into action, specific actions areas (prevention, harm reduction, treatment) and reporting on activities (ex. communication and evaluation)

Process

- Community Drug Strategy for the City of Greater Sudbury (CDS) has, since 2015, aimed to address drug use and drug-related harms through the five pillars of (1) health promotion and prevention of substance misuse, (2) harm reduction, (3) treatment, (4) enforcement and justice, and (5) sustaining relationships. It is co-led by SDHU and the Greater Sudbury Police Service and is a coalition of several key community partners. (Note that the health unit is also involved in drug strategies in the surrounding districts, but that this discussion refers to what was done specifically for the CDS)
- Fall 2016 ODPRN report noted that Greater Sudbury exceeded provincial averages in opioid use, high-strength opioid use, opioid maintenance therapy, emergency department visits, hospital admissions and deaths. This in addition to major opioid-related events in 2016 such as the federal/provincial opioid summit led to a decision at CDS Executive Committee in January 2017 to go ahead with creation of local opioid action plan.
- Conducted two pre-meetings with relevant CDS partners on (1) naloxone supply and distribution and (2) data available to inform monitoring (ex. early alerting) and action.
- These meetings were followed by a stakeholder consultation for feedback on a proposed action plan outline (informed by pre-meetings, informal consultation with other health units). Stakeholders included representatives from the City of Greater Sudbury, public health, enforcement, community-based organizations, health care, schools, academia and persons with lived experience.

Facilitators/successes

- Pre-existing drug strategy (CDS)
- Relationships/dialogue (both with community partners and with other PHUs/PHO)
- City of Greater Sudbury's interest in making mental health and addictions a priority
- Alignment of interests with partners and stakeholders

Barriers

- Resources
- Complexity / no best practices
- Challenges knowing patterns of illicit drug use
- Engaging health care providers who prescribe opioids
- Including public viewpoints vs lived experience

Dr. Vera Etches, Deputy Medical Officer of Health, Ottawa Public Health

Panel presentation summary

Priorities

- Address needs of parents, teachers and youth (education sessions, including information on mental health)
- Improve data for informed responses to risk in the community (collate local data in "real time")
- Enhance access to naloxone (via pharmacies, PHU and first responders)
- Increase public awareness and education (via an on-line and social media campaign)
- Align treatment options with community need (LHIN, in conversation with OPH)
- Protect the community from exposure to illicit substances (Police)
- Enable a coordinated approach through a secretariat for a comprehensive drug strategy that addresses the four pillars of prevention, treatment, enforcement and harm reduction
- Reduce childhood trauma as a risk factor for substance misuse through support to Early Years Centres
- Assist people using substances to stabilize their lives and reduce use through supportive housing
- Maintaining public confidence and the credibility of the PHU
- Identifying gaps in current services and plans
    - Pharmacy preparedness for an increased demand for naloxone
    - Youth treatment services in community settings and supports for parents
    - An exercise of the response plan for a cluster of overdoses due to opioids

Process

- Inter-agency plans to respond to overdoses began in 2014 with an overdose response task force
- Partnership: ER, PHU, EMS, coroner, police following deaths at a music event
- Added others to table in 2017: LHIN, schools, CHC
- Preventive work – public messaging
- Evolved into Nov 2016 Stop Overdose Ottawa campaign
- PHU as facilitator/communicator/coordinator/ advocate
- Heightened interest following a PHU/police joint news release to alert the public about harms of counterfeit pills and risk of overdose, with a related death in young person and later confirmation of fentanyl in pills
- Supported community information sessions with parents and youth, and in schools
- Enhanced data mapping, pursuit of additional indicators from partners

Facilitators/successes

- Multiple partners engaged, building on previous partnerships and responses
- Use of the network of partners to validate any “spikes” seen in overdoses in the syndromic surveillance system
- Use of the IMS structure – teen death resulting in requests that overwhelmed usual capacity
- Politicians involved
- Using harm reduction networks
- Patients First influence – PHU invited to the table to help with healthcare planning
- Opportunity for longer-term thinking about more “upstream” investments needed (e.g. in housing, mental health supports and early childhood development)

Barriers

- Lack of a secretariat and support to coordinate a more comprehensive approach across the community under the four pillars of a comprehensive drug strategy
- Some administrative databases are not designed for generating reports on the variables of interest/use for opioid overdose surveillance. Real time reporting makes use of syndromes which are not specific to opioid overdoses.

Claire Farella, Manager, Manager Sexual Health & Harm Reduction, Leeds, Grenville and Lanark District Health Unit

Slides on next page.

Community Response for Problematic Opioid Use in Leeds, Grenville and Lanark "Our Local Journey"

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Leeds Grenville Lanark Region

- **Population is 165,000 spread over 6330 km²**
- **22 municipalities / 60% residents live in rural areas**

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Our Journey

June 2016

Concerned about fentanyl situation

LGL Community Harm Reduction Committee

Key Questions

- ✓ **What is our current situation?**
- ✓ **What is making the situation better or worse?**
- ✓ **What possible solutions, interventions and actions can be taken to address the situation?**

Our Journey

- **Stakeholder meetings**
- **Data collection**
- **Education Day - Dec 2016**
- **Development of a plan**
- **PHO/HU's in SE LHIN host "Cluster Overdose Workshop"**

Our Journey…

Current Priorities for the Communities of Leeds Grenville Lanark (LGL) based on 3 scenarios

1. **Local overdose cluster response plan**
2. **Prevention and harm reduction strategies to address illicit fentanyl in our community.**
3. **Address problematic use of prescription opioids.**

Our Journey

Teen Death in February 2017

- **Community concern escalated**
- **HU activates Incident Management System**
- **Collaboration with schools**
  - **Information**
  - **Naloxone in first aid kits**

Lanark County Involvement

- **CCG meeting with municipalities**
- **Mass Overdose plan**
- **Lanark County Council advocacy**

Challenges

- **Limited resources and competing priorities**
- **Lack of provincial direction/strategy in the beginning stages**
- **Lack of local data that was current (this is improving)**

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Facilitators

- **Strong relationships**
- **Activate IMS internally to shift HU resources**
- **Establishment of local communication networks Local Alert that Fentanyl is here**
- **MOH supports**
- **Provincial Strategy/ Data Reporting Tools**

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Successes

- **Draft Cluster Overdose Response Plan**
- **Promote mass distribution of Naloxone Kits**
- **Work with School Boards – Naloxone in Schools**
- **Participation in community presentation**
- **Education/Training of First Responders**
- **Advocacy**
- **Mass Communication Plan**
- **Planning Education for Primary Care**

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Thank you

Visit our website:
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Appendix F: SWOT analysis activity

A frequently-used tool in planning is the SWOT Analysis. An analysis of strengths, weaknesses, opportunities and threats (SWOT) permits organizations to identify assets which can be strengthened, internal and external barriers which may arise, as well as external opportunities to leverage during the design and implementation of a program.

During the workshop the six groups were asked to identify the strengths and weaknesses internal to their organization or Public Health as well as the opportunities and threats external to their organization or Public Health for the following areas:

1. Prevention
2. Treatment
3. Enforcement
4. Harm Reduction
5. Community engagement
6. Communication with the public

The first four discussion topics were chosen as they form the "four pillars", or principals of an established approach to drug policy.[7] The fifth and sixth topics were chosen during the workshop as they came up frequently in the morning and early afternoon discussions. The notes are taken directly from ideas generated by participants. If an item wasn't clear following the workshop, the facilitator has attempted to provide additional clarification with square brackets.

As you look to adapt or build upon this table, keep in mind that the strengths listed might be weaknesses for some organizations or vice versa. These were areas identified by workshop participants based on their own experiences and organizations. Given time constraints for the groups, these lists are not exhaustive. We recommend that you look across the discussions to find areas/suggestions which may be relevant to another category.

PILLAR/DISCUSSION TOPIC: PREVENTION

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Programs in place HBHC Early Development Instrument –building resiliency Pre-existing infrastructure of harm reduction and substance use [services] Expected to provide leadership, have health promotion programming in place School based HBHC Have ability to facilitate action to address SDOH Already have primary prevention orientation with health promotion	Program silos – competing priorities Disconnect between Substance use, Prevention and harm reduction programming Preventative interventions that are evidence-based are limited (ones that are public health action only vs address poverty) No comprehensive strategy to prevent substance use via support to child development	Partnerships/relationships Media, public opinion Provincial requirement to have opioid plans Provincial requirement for LHINs to be engaged Shift in thinking re: stigma? (increased public concern about "opioid crises") Mobilized around common concern	Community in general does not understand harm reduction - Want prevention only Rapidly changing priorities "flavour of the month"? Perception of overdose as simply a consequence of bad decisions Funding Need programs to address early trauma Cultural "prohibitionist" thinking Partners don't know about importance of addressing SDOH Can't affect SDOH quickly Perception of public health role (perception of PH as treater)

PILLAR/DISCUSSION TOPIC: TREATMENT

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Relationships with clients Education Data monitoring "Myth busting" [Public health has experience with health education to 'bust myths' around health or health services] Systems thinking Identification of gaps in the community Public health staff Facilitation	Relationships with some partners [is limited or weak] (e.g., primary care) Staff stress Public health staff may not understand addiction treatment [knowledge gap]	Provide naloxone kits [in treatment settings] Train staff on overdose Train clients on overdose Identify gaps Advocacy [Could provide] Navigation [of treatment system] Patients First Naloxone at other addiction programs [Can look at]Systemic level [e.g., partnering in system-wide planning] [Can look at] Individual level [(e.g., referring when someone comes in for naloxone kit)] Identify opportunities for transitions Integrate harm reduction	Capacity Funding Quality of care Wait lists Lack of consistency Philosophy (abstinence) Fragmented Silos (mental health, etc.) Not evidence-based Limited after-care

PILLAR/DISCUSSION TOPIC: ENFORCEMENT*

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Existing work on data sharing Good Samaritan Law – reducing hesitancy to call 911 during a life-threatening overdose event Harm reduction programs (e.g., Needle exchange, Patch-for-patch)	Public health does not have drug enforcement powers Lack of ability of public health to enforce our own recommendations [and there might not be the will/interest internally to prioritize this issue]	Encourage police and court services to divert PWUD toward treatment programs in lieu of criminal justice system While protecting patient confidentiality, collaborate with enforcement agencies to assist them in identifying the upstream supplier of the illicit substances Inform efforts to support populations at high risk for overdose/opioid-related harms after re-entering the community post-incarceration Lobby drug benefits providers towards holistic approach to pain management (e.g., reserve opioids to last-resort usage) Network with police to inform about strategies Public health detailing – work with doctors and pharmacists re: supply chain Promoting alternate pain relief strategies Inform legislation if able to support law enforcement Decrease stigma around PWUD within police services Opportunity for education regarding the SDOH	Lack of trust on the part of PWUD towards any party perceived to be in any form of authority (e.g., mistaking public health practitioners for police) Rampant misinformation about the topic (e.g., “alternate facts”; fake news) Prescription laws pushing people towards illicit sources if/when suddenly cut off from legitimate supply (e.g., doctor no longer prescribing) Lack of clarity on source [of opioids] Lack of ability of public health to enforce recommendations [and there might not be political will to adopt recommendations by Public Health]

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
		Tracking prescribing practices to monitor opioid-related harm incidences Inform prescribers about risks to stopping prescriptions to patients Help inform efforts to support/develop requirements for labelling opioid prescription bottles to include explicit warnings of addictive properties	

* Please note that the participants felt there was very limited role of public health in the "Enforcement Pillar", so we largely took the approach of identifying what opportunities may exist for public health to influence the more traditional enforcement-type agencies to consider diversion of cases away from the criminal justice system toward to treatment programs.

PILLAR/DISCUSSION TOPIC: HARM REDUCTION

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Well-established harm reduction/needle exchange/safe inhalation/naloxone program	Took an IMS to mobilize resources due to lack of organizational buy-in	Pharmacy interest	Risk of partner burn out
Organization supports a harm reduction philosophy	No harm reduction philosophy	ONP and ONPP	Stigma
Organizational capacity	Lack of resources	Community partner satellite sites for Needle and Syringe Program (NSP)	Negative perceptions of PWUD
Funding to satellite sites	Harm reduction programming is primarily focus in urban areas (for rural PHUs)	CDAS	Fear in calling 911 in overdose situations
Fantastic team and experience	Separation of harm reduction and prevention programs at PHU (left hand/right hand)	Good Samaritan Law	Not involving people with lived experience
Building on uniqueness of partners to serve different populations better e.g., PWUD vs concerned parents	Change in management	Engaged community partners (don't want to get caught behind)	Continued partner engagement if no or small numbers of opioid-related harms
Institutional memory	Lots of staff retiring	To partners this can translate into working bigger issues like the SDOH	Large geographic expanse
Strong epidemiology and program evaluation team	Internal attitudes towards PWUD	Shifting views of political/other leaders with increased buy-in regarding HR	Historical broken relationships
Strong ties with naloxone providers	Differing internal philosophies on community engagement	Different organizations offering needle exchange to different populations	NIMBYism [Not in my backyard]
	Competing priorities	Partner organizations' relationships with their clients	

PILLAR/DISCUSSION TOPIC: COMMUNITY ENGAGEMENT

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Good partnerships already exist with community organizations Resources- as health unit within a regional structure External partnerships providing access to various populations Willingness to share information and data (real-time) There is an existing experience/infrastructure for community engagement Many organizations receive different valuable information from clients about how they want to be engaged	Funds get diverted to clinical services Lack of internal policies for community engagement Resources (understaffed for high demand, meetings take time away from clients) Irregular or inconsistent provision/access to mobile services Political restrictions as a health unit within a regional structure Lack of people with lived experience on governance bodies of organizations Stigma related to drug use Unable to be creative/innovative/risqué with messaging	Persons who use drugs (PWUD) are engaged and organizing themselves More flexibility in the new OPHS Acknowledgment of opioid crisis has motivated various groups/organizations to help Harnessing the experience of other health units Increased attention to issues of opioid-related harms	Controversial subject matter More flexibility in the new standards No funding increases for public health Media can hurt Takes time and resources to build trust with clients Lack of community awareness of Public Health

PILLAR/DISCUSSION TOPIC: COMMUNICATIONS WITH PUBLIC

Strengths (internal)	Weaknesses (internal)	Opportunities (external)	Threats (external)
Powerful voice (MOHLTC provincial message) Internal communications department for support (media capacity building) Media relations protocol Prioritization of public release of health status information	Hesitancy to share "work in progress" as opposed to "final products" (cost-benefit; perceived as "doing nothing" vs. releasing too early) Risk-averse We have no physical presence in county (no media, etc. within that county office) Too many internal stakeholders to review the message (accountability) Lack of social media platform Contradiction between prevention and harm reduction? (How to message to public)	Engage media on drug strategy Positive social media influences Better relationship with LIHNs for consistency of message Regular communication between key stakeholders so you're on the same page and get a heads up on actions they may be implementing Increased sharing of public health communications between organizations	Lack of acceptance or understanding about harm reduction (values, etc.) Public opinion of lack of response (e.g. legalizing) Social media is unpredictable Regular media [writing stories that may not align public health message or evidence] Stakeholders "getting to media" first, having more influence [other stakeholders may be able to comment more quickly due to communications processes within a health unit. Without strong partnerships may not have aligned message.] Inaccurate information reported too soon, can we have any guidelines/protocol? Difficult to do damage control Inaccurate information in media (e.g. carfentanil rumor)

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