A Call for Family-Based Treatment Initiatives in Saskatchewan: A Harm Reduction and Recovery Approach

Joint Submission to the Drug Task Force

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Background

This discussion paper is a joint submission between the Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) and Saskatchewan Association of Social Workers (SASW) in response to Saskatchewan's Drug Task Force's (DTF) Community Engagement Initiative. Registered Psychiatric Nurses (RPNs) and Registered Social Workers (RSWs) often work together as part of multidisciplinary teams to support Saskatchewan residents who are using or impacted by substance use. A joint submission serves as an example of the possibilities interdisciplinary collaboration can offer in reducing the harms of problematic substance use. For more information on RPNAS and SASW, and the roles of our respective professions, see Appendices A and B. We would also like to express our appreciation for being given the opportunity to provide this submission.

Content within this paper is informed by a review of current literature, an environmental scan, and existing policy and program initiatives. The literature review and environmental scan were not exhaustive but show common themes and a strong evidence base for family-based treatment as a harm reduction-informed policy and practice. Family-based treatment approaches also address the DTF pillar of recovery. The evidence base for such approaches is consistent with the values, ethics, and standards of practice for RPNs and RSWs.

Executive Summary

An opportunity exists in Saskatchewan to expand evidence-informed, community-driven policy and practice relating to substance use. RPNAS and SASW recommend that the DTF, or a committee/stakeholder designate, create a call for community-developed, family-based substance use treatment programs and interventions.

Family-Based Treatment

Evidence shows that childhood experiences set children up for their future. Adverse experiences impact the health and well-being of children into adulthood. Exposure to problematic substance use (e.g., alcohol, illicit and prescription drugs, solvents), caregivers who have mental illness, violence, abuse, neglect, and poverty are some of the key triggers for childhood trauma, which can lead to physical and mental illness in adulthood (Centers for Disease Control and Prevention, 2021). The RPNAS and SASW see significant community benefit in creating treatment programs and substance use interventions which address the needs of entire families. Family-based substance use programs can have positive impacts by reducing risks and increasing factors that prevent children from experiencing traumatic events. In addition to prevention and harm reduction, acknowledging the relationship between adverse experiences, substance use, and mental health can inform recovery treatment approaches which address the needs of people who use substances and their family members of all ages.

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Literature Review

Approaches to treating addiction have traditionally focused on the individual using substances with the goal of reducing their physical, mental, and emotional symptoms related to the use (Copello, 2010). An approach that considers the families and communities impacted by substance use can have multiple benefits for individuals, families, and communities. Relevant grey and white literature were reviewed to identify the following:

- Adverse childhood experiences are an important consideration in substance use policy and practice informed by social determinants of health.
- Research relating to adverse childhood experiences and substance use disorders show that increased adverse childhood experiences are associated with landmarks of opioid use risk (i.e., age of opioid initiation, current intravenous drug use, and overdose) (Stein et al., 2017).
- When treatment options are limited, parents/guardians are often faced with the choice of separating from their children (e.g., placing them in the care of family members, or in the care of the Ministry of Social Services) or foregoing substance use treatment to remain with their children.
- Family-based treatment which considers the developmental phase of the person using substances, as well as the phase of the individual family members and combined family unit, can also support a reduction in the harms of substance use for older adults (Plant & Holland, 2018).
- Including families of all ages and stages in addressing substance use can have positive impacts and reduce the harms of substance use both on the person using substances and their family members.
    - Preliminary evidence suggests treatment that involves families is at least as effective (Lebensohn-Chiavlo et al., 2019) or more effective than evidence-based individual treatments and can support sustained recovery from substance use after treatment completion (Copello, 2010; Latimer et al., 2004; Karki et al., 2012; Silverstein, et al., 2021).
    - A systematic review found the most effective approach to substance use disorders was family-based “intervention that improved family functioning, support, monitoring, normative beliefs, social skills, and self-efficacy” (Karki et al., 2012, p. 408-409).
    - For adolescents, family-based interventions are shown to reduce substance use, improve health, decrease involvement in crime, and improve family functioning (Lebensohn-Chiavlo et al., 2019; Sherman, 2010).
    - There might be opportunities to expand harm reduction interventions to rural and remote communities through the involvement of supportive family members (Jackson et al., 2011).
    - Family treatment with a focus on harm reduction can help families navigate between providing healthy and unhealthy kinds of support (Denning, 2010).
    - Family treatment can also assist families respond to loved ones who use substances in a way that helps them get into treatment (Knopf, 2018; Knopf, 2019).
    - Providing treatment to families where the person using substances is not involved can also reduce harm (Copello, 2010).
    - Family-based treatment acknowledges family members’ needs as well as the person using substances, moving beyond an individual view of substance use; treating family members can lead to changes within the person using substances (Copello, 2010).

- Enhanced community recovery services that involve the entire family may be of benefit in addition to family residential treatment.
- Family-involved and family-based treatment addresses the *Saskatchewan Mental Health and Addictions Action Plan* recommendation to implement a mental health and addictions system that is family and community centered (recommendations 5, 8, 10, and 13) (Stockdale Winder, 2014).
- Involving families and using harm reduction approaches developed at a community-level could support the Truth and Reconciliation Commission of Canada's (TRC, 2015) first and fifth Calls to Action. Calls 1 and 5 address keeping Indigenous families together and supporting the development of culturally appropriate parenting programs.
- Community-driven approaches that acknowledge the social nature of substance use could also support movement related to the TRC (2015) calls to reduce health disparities between Indigenous and non-Indigenous people and communities (calls to action 18 to 20).
- Expansion of family treatment programs and community-based family intervention could support the DTF goals to decrease deaths, overdoses, and use of substances that lead to overdose and death.
- Family treatment programs can be designed by community members and agencies to meet local needs.

Environmental Scan

Saskatchewan initiatives related to family-based treatment along with programs within our Prairie counterparts were reviewed.

- Saskatchewan has limited options for families to remain together while parents/guardians enter residential or substance use treatment.
- Saskatchewan programs that support families include:
    - Family Centered Addictions Program, Ranch Ehrlo Society
        - Families can attend treatment together; there are services for the individual who uses substances and their family members. Prevents separation of parents from children when parents are getting treatment for substance use (Ranch Ehrlo Society, 2021).
    - Intensive Family Support, Foxvalley Counselling Services Inc.
        - Supports families for up to 6 weeks. Families can stay together, children can remain in their home while parents receive intensive support and connection with services (Foxvalley Counselling Services Inc., n.d.).
- Within Alberta, there are services available to families at various phases of development:
    - Calgary Family Therapy Centre
        - Provides family therapy for families with members of all ages, services are not limited to substance use (Calgary Family Therapy Centre, 2021).
    - CASA Family Therapy Program, Child, Adolescent and Family Mental Health
        - For families with complex dynamics and at least one child under 18 years of age who has been diagnosed with a mental health disorder (including substance use) (Child, Adolescent and Family Mental Health, n.d.).
    - Mothers and Children Program, Alcove

        - A residential 12-week program that involves individual programming with the addition of parenting training, and relationship support for mothers and their children. Allows children to remain with their mothers who are in treatment for substance use. There is counselling available for children within the program (Alcove, 2015).
    - Sahara Family Case Management Program - Punjabi Community Health Services Calgary
        - Provides case management and counselling to South Asian families in Calgary (Punjabi Community Health Services Calgary, n.d.).
- Manitoba has two programs that support families. One is focused on comorbid disorders and the other program is rooted within Indigenous culture and traditions:
    - Addictions Treatment Services Program, Behavioural Health Foundation
        - Long term, residential programming for men, women, and families experiencing substance use and co-occurring mental illness. Treatment length is open-ended (Behavioural Health Foundation, 2019).
    - The Mikaaming Mino Pimatiziwin Healing Lodge
        - The Mikaaming Mino Pimatiziwin Healing Lodge is a family treatment facility for First Nation and Inuit families who are having problems with substance use. The program is based on the culture and traditions of Indigenous People. It includes services for up to four families (Mikaaming Mino Pimatiziwin Healing Lodge, n.d.).

Conclusion

Family treatment aligns with DTF pillars of harm reduction, prevention, and recovery. Expanding to a social model to address substance use problems can have benefits for a variety of people, including both individuals who use substances and their family members. Based on the environmental scan, it is unclear what options for family treatment exist within Saskatchewan for families without young children. There are examples of community-based organizations that have begun to address this gap for families with children (i.e., Ranch Ehrlo Society and Foxvalley Counselling Services' programs). It is likely that this approach to treatment is under-utilized in Saskatchewan and that expanded provision of family-based treatment programs would decrease the harms related to substance use while preserving families. Individuals, families, and communities impacted by substance use have lived experience that is important in determining solutions at a community level.

Recommendations:

The RPNAS and SASW recommend the following

1) Policy and funding decisions that consider the impact of substance use on families, prioritizing family preservation and reducing adverse childhood experiences.
2) The DTF or a designate committee/stakeholder group call for proposals from Saskatchewan communities for family-based treatment pilot project

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Appendix A: Registered Psychiatric Nurses Association of Saskatchewan

The Registered Psychiatric Nurses Association of Saskatchewan (RPNAS) regulates psychiatric nursing as a distinct profession. The RPNAS registers psychiatric nurses in Saskatchewan, sets and maintains the standards for RPN practice and licensure, evaluates and approves psychiatric nursing education programs, presides over disciplinary and peer review processes, and advocates for quality and integrated mental health services and policy.

RPNs are autonomous professionals. They work collaboratively with clients and other health care team members to coordinate health care and provide client-centered services to individuals, families, groups, and communities. RPNs focus on mental and developmental health, mental illness and addictions while integrating physical health care and utilizing bio-psycho-social and spiritual models for a holistic approach to care.

RPNs provide and coordinate services across the continuum of care. They are obligated to create and maintain therapeutic and collaborative relationships with clients (including individuals, families, groups, and communities) and use evidence-informed practices to deliver safe, competent, and ethical psychiatric nursing services. Quality psychiatric nursing care includes respecting individual rights and choices, including individuals' right to live at risk. RPNs also recognize the impact of socio-economic and political environments on health and mental health and advocate for sufficient and equitable resources for all people. RPN practice aligns with the DTF pillars, particularly the pillars of prevention, recovery, and harm reduction.

Information can be found at www.rpnas.com.

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Appendix B: Saskatchewan Association of Social Workers

The Saskatchewan Association of Social Workers (SASW) is a member-based organization that governs the profession of social work and serves and protects the public interest through: regulation of the social work profession; support to competent and ethical social work practice; promotion of the profession; and advocacy for social justice and well-being for all. We are an organizational member of the Canadian Association of Social Workers (CASW), adopting its *Code of Ethics* (2005). Registered social workers are spread across the province and employed by hospitals, schools, mental health and addictions services, government departments, First Nations agencies, community-based organizations, and other similar institutions. There are 2,400 Registered Social Workers in Saskatchewan.

> Social work focuses on the person within their environment and recognizes the importance of family, community, culture, legal, social, spiritual, and economic influences that impact the well-being of individuals, families, groups, and communities. Social work applies a strengths-based perspective and views individual, families, and communities as resourceful, resilient, and having capacity. Principles of respect for the inherent dignity and worth of persons, the pursuit of social justice, and culturally responsive practice that applies an anti-oppressive lens to all areas of practice and is grounded in ethics, values, and humility, are central to social work.
>
> Social work practice responds to needs of individuals, families, groups, and communities and addresses barriers and injustices in organizations and society. Social work focuses on improving health and social well-being using the social determinants of health framework when delivering services, navigating systems, and advocating for equitable access to and improvement of the multiple dimensions that impact health and well-being. Social work engages people and communities to address life challenges and traumatic events, to create change, and build resiliency. Social work also collaborates with other professionals, communities, and organizations to provide services, improve conditions, and create opportunities for growth, recovery, and personal development (CASW, 2020).

For more information on the SASW, visit www.sasw.ca.

Harm Reduction Considerations for Substance Use in Saskatchewan

Submission to the Drug Task Force

Saskatchewan Association of Social Workers

October 2021

Harm Reduction Considerations for Substance Use in Saskatchewan

Background

This discussion paper is submitted by the Saskatchewan Association of Social Workers (SASW) in response to Saskatchewan's Drug Task Force's (DTF) Community Engagement Initiative. In addition to the joint submission by the SASW and the Registered Psychiatric Nurses Association of Saskatchewan, *A Call for Family-Based Treatment Initiatives in Saskatchewan: A Harm Reduction and Recovery Approach,* the SASW would like to highlight additional considerations in harm reduction policy and practice. In Saskatchewan, social workers serve in a variety of roles to support Saskatchewan residents who are using or impacted by substance use. For more information on the SASW and our role, see Appendix A. We would like to express our appreciation for being given the opportunity to provide this submission.

Content within this paper is informed by a review of current literature, an environmental scan, and existing policy and program initiatives. The literature review and environmental scan were not exhaustive but show common themes and a strong evidence base for interventions that do not require abstinence from substances and their resulting reduction in related harms. The evidence base for harm reduction approaches is consistent with the values, ethics, and standards of practice for social workers.

Executive Summary

An opportunity exists in Saskatchewan to expand evidence-informed, community-driven policy and practice relating to substance use. Currently, there is a lack of government funding support for community-based harm reduction initiatives, especially safe consumption sites. The evidence for safe consumption sites is clear; they reduce harm, save lives, and result in overall cost savings. Support for safe consumption sites puts individuals' inherent dignity at the forefront, showing people who use substances and their families that they deserve support, regardless of the barriers faced in maintaining abstinence. It is promising to see harm reduction included in the DTF's Guiding Pillars; it is important that any solutions to address the harms relating to substance are concrete and informed foremost by the lived experiences of those most impacted, as well as by evidence. The Truth and Reconciliation Commission's (TRC) Calls to Action[13] provide guidance in several areas relating to the DTF's Guiding Pillars; action plans arising from community engagement must consider the Calls to Action and how they can be addressed in local and regional contexts. Harm reduction approaches must also extend beyond the scope of individual substance use, considering and addressing the context (i.e., historical, environmental, systemic) in which substance use harms are occurring. The SASW recommends the DTF prioritize funding support for initiatives that reduce the harms of substance use without requiring abstinence, are community- and peer-led, multi-level and multi-sectoral, and evidence-based. Moving beyond individual-scale approaches, solutions aimed at resolving poverty, preserving families, addressing social determinants of health, and addressing systemic oppression will reduce the harms and costs of substance use at many levels.

Harm Reduction

Harm reduction as a response to substance use reflects social work values, ethics, and standards of practice. It is client-centered, affirming that every individual is worthy and unique, and entitled to justice, to freedom, and to be a part of the community.[6,15] While outcome evidence for common substance use treatment approaches varies,[8,9,11,16] it is clear that traditional abstinence-based models are a barrier for people who use substances to engage with supports.[14] Harm reduction interventions, such as safe consumption sites, remove this barrier. As a component of the ethical obligation to competence in social work practice, social workers encourage "innovative, effective strategies and techniques to meet both new and existing needs, and, where possible, contribute to the knowledge base of the profession".[15] Many social workers employ harm reduction philosophies and interventions in serving residents of Saskatchewan.

Literature Review

- Evidence on safe consumption sites show:[6]
    - They do not increase crime rates in their geographic area.
    - They dramatically decrease fatal overdose rates.
    - They serve as a referral source for participants, providing the opportunity for contact and relationship-building with health care and community service providers.
    - They increase public order through decreasing in public drug use, injection-related trash, and the presence of suspected drug dealers in surrounding areas.
    - They do not lead to increase in injection drug use initiation or increase relapse rates of injection drug use.
    - They can decrease HIV infections.
- Medication assisted treatments (MATs) for opioid use are shown to be highly effective in supporting abstinence and relapse prevention across different treatment approaches and settings (e.g., opioid agonists, partial agonists, and antagonists).[9]
- Relapse rates are among the highest after short-term inpatient treatment and the risk of overdose death is highest following release from controlled settings (e.g., incarceration, short-term inpatient treatment).[1]
- Managed alcohol programs (MAPs) have shown promise as a harm reduction intervention for alcohol use, decreasing harms related to alcohol consumption and saving costs overall (i.e., health and social services).[10]
- The Canadian Harm Reduction Policy Project documents harm reduction policies in Canada, emphasizing the need policy to endorse harm reduction in practice.[7,17]
- The Canadian Aboriginal AIDS Network (CAAN) and the Interagency Coalition on AIDS and Development (ICAD) released their *Policy Brief: Indigenous Harm Reduction – Reducing the Harms of Colonialism*, providing recommendations for governments to utilize Indigenous approaches in implementing harm reduction policy.[2]

Environmental Scan

- There is an increasing number of opioid substitution/MAT providers across Saskatchewan.
- Managed Alcohol Programs in Saskatchewan: Lighthouse (Saskatoon); Phoenix Residential Society HOMES Program (Regina).
    - Alberta has several MAPs located in Calgary, Edmonton, and Lethbridge.
    - Managed Alcohol Programs in Manitoba: Sunshine House (Winnipeg); Mainstreet Project (Winnipeg).
- In Saskatchewan, safe consumption sites are not government-funded and are based in Regina and Saskatoon only.
    - Existing sites include Prairie Harm Reduction (Saskatoon) and Nēwo Yōtina Friendship Centre (Regina).
    - Alberta Health Services supports supervised consumption services in Calgary, Edmonton, Red Deer and Lethbridge.
    - Out of Vancouver's Insite's (supervised injection site) more than 2 million visits, including 200 overdose events, there were no overdose deaths at the facility.[6]
- The SASW recently released *Guidelines for Social Workers in the Administration of Naloxone*, affirming that social workers trained in the administration of naloxone may do so in the event of suspected or actual overdose, where a qualified medical professional is not available to manage the situation.[12]
- The Canadian Harm Reduction Policy Project (CHARPP) provides a framework with indicators designed to measure the quality of formal harm reduction policies.

  - For a policy to score highly on CHARPP indicators, it must describe an approach to harm reduction reflecting certain key principles (Appendix B).[5]
- The Canadian Association of Social Workers (CASW) has publicly voiced support for harm reduction initiatives and released its *Statement on Decriminalization of Personal Use of Psychoactive Substances* in 2020; this document affirmed that criminalization continues to have harmful consequences and poor outcomes, while a public health approach has greater capacity to reduce harms.[3]

Conclusion

Harm reduction interventions and approaches (e.g., safe consumption sites, MAT, MAPs) have a strong evidence-base and appear to be under-funded in Saskatchewan. Community-based organizations have begun to fill gaps in Saskatchewan's existing approaches to addressing substance use, such as Regina and Saskatoon's safe consumption sites currently operating without provincial government funding. Additional funding would allow for expansion of these important services. The existing literature base includes excellent policy frameworks for the DTF to utilize in creating innovative and responsive solutions, such as CHARPP's harm reduction policy framework and CAAN/ICAD's policy brief providing recommendations for Indigenous approaches to harm reduction. Harm reduction policy must also move beyond individual considerations, considering the larger context in which substance use occurs (i.e., historical, environmental, systemic). The CASW supports a public health response to substance use, advocating for decriminalization of illicit psychoactive substances for personal use.[3]

<u>Recommendations:</u>

The SASW recommends the following

1) Policy and programming have strong evaluation mechanisms to further contribute to a regional evidence-base for promising approaches to substance use treatment and harm reduction.
2) Direct funding to approaches that are evidence informed (e.g., MAT, alternatives to short-term inpatient treatment, MAPs).
3) Targeted, sustainable funding for harm reduction initiatives, including safe consumption sites.
4) Evaluate the need for safe consumption sites and other harm reduction initiatives outside of Regina and Saskatoon.
5) Utilize CHARPP's framework indicators in policy and funding decisions, an important factor of which is inclusion of those impacted by substance use (i.e., lived experience) in such decisions.
6) Utilize CAAN/ICAD's *Policy Brief* recommendations to implement Indigenous approaches to harm reduction, which would also relate to TRC calls to action regarding improving social and health outcomes for Indigenous communities.
7) Work with the federal government to decriminalize possession of illicit psychoactive substances for personal use, while also considering possibilities and options for decriminalization at municipal and provincial levels.
8) Policy approaches based on principles of social justice, human rights and equity, evidence-informed policy and practice, and approaches that address determinants of health.[3]

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Appendix A: Saskatchewan Association of Social Workers

The Saskatchewan Association of Social Workers (SASW) is a member-based organization that governs the profession of social work and serves and protects the public interest through: regulation of the social work profession; support to competent and ethical social work practice; promotion of the profession; and advocacy for social justice and well-being for all. We are an organizational member of the Canadian Association of Social Workers (CASW), adopting its *Code of Ethics* (2005). Registered social workers are spread across the province and employed by hospitals, schools, mental health and addictions services, government departments, First Nations agencies, community-based organizations, and other similar institutions. There are 2,400 Registered Social Workers in Saskatchewan.

> Social work focuses on the person within their environment and recognizes the importance of family, community, culture, legal, social, spiritual, and economic influences that impact the well-being of individuals, families, groups, and communities. Social work applies a strengths-based perspective and views individual, families, and communities as resourceful, resilient, and having capacity. Principles of respect for the inherent dignity and worth of persons, the pursuit of social justice, and culturally responsive practice that applies an anti-oppressive lens to all areas of practice and is grounded in ethics, values, and humility, are central to social work.
>
> Social work practice responds to needs of individuals, families, groups, and communities and addresses barriers and injustices in organizations and society. Social work focuses on improving health and social well-being using the social determinants of health framework when delivering services, navigating systems, and advocating for equitable access to and improvement of the multiple dimensions that impact health and well-being. Social work engages people and communities to address life challenges and traumatic events, to create change, and build resiliency. Social work also collaborates with other professionals, communities, and organizations to provide services, improve conditions, and create opportunities for growth, recovery, and personal development.[4]

For more information on the SASW, visit www.sasw.ca.

Appendix B: Canadian Harm Reduction Policy Project Framework for Assessing Quality of Harm Reduction Policies

Population Quality Indicators

Includes 9 population indicators based on the premise that high-quality harm reduction policies characterize service populations accurately when they:

1. Recognize that stigma and/or discrimination are issues faced by people who use illicit drugs
2. Affirm that people who use drugs need to be involved in policy development or implementation
3. Acknowledge that not all substance use is problematic
4. Recognize that harm reduction has benefits for both people who use drugs and the broader community
5. Acknowledge that a harm reduction approach can be applied to the general population
6. Affirm that women are a key population
7. Affirm that youth are a key population
8. Affirm that indigenous people are a key population
9. Affirm that one or more groups of LGBTQI (lesbian, gay, bisexual, trans, queer and questioning, and intersex) people are a key population

Program Quality Indicators

Includes 8 program indicators based on the premise that high-quality harm reduction policies should:

10. Acknowledge the need for evidence-informed policies and/or programs
11. Recognize the importance of preventing drug-related harm (rather than just preventing drug use, or blood-borne, or sexually transmitted infections)
12. Discuss low-threshold approaches to service provision
13. Specifically address overdose
14. Recognize that reducing or abstaining from substance use is not required
15. Consider harm reduction approaches for a variety of drugs and modes of use
16. Discuss harm reduction's human rights (e.g., dignity, autonomy) dimensions
17. Consider the social determinants (including income, housing, and education) that influence drug-related harm

Source: Hyshka, E., Anderson-Baron, J., Karekezi, K., Belle-Isle, L., Elliott, R., Pauly, B., Strike, C., Asbridge, M., Dell, C., McBride, K., Hathaway, A., & Wild, T. C. (2017). Harm reduction in name, but not substance: A comparative analysis of current Canadian provincial and territorial policy frameworks. *Harm Reduction Journal*, 14(1), 50. https://doi.org/10.1186/s12954-017-0177-7

SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Evidence-Informed Responses to Evolving Opioid-Related Harms in the Province of Saskatchewan

October 2021

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This discussion paper was prepared for the Saskatchewan Drug Task Force (DTF) to address the ongoing public health crisis related to opioid-involved overdoses and deaths[2] in the province. The purpose of the paper is to outline opportunities for reducing the occurrence of overdoses and preventing overdose-related harms, including deaths in Saskatchewan. Considering pertinent environmental and demographic factors, it argues strongly for an evidence-informed, broad-based and community-driven approach to harm reduction in the province.

INTRODUCTION

In recent years, Canada's leading cause of opioid-related mortality has changed from prescription pharmaceutical opioids and their subsequent diversion to the community to toxic illicit synthetic opioids. The corrective measures towards the regulation of pain management (Busse et al., 2017), although needed, were met with the increased supply of illegal drug markets by highly toxic illicit/synthetic opioids such as fentanyl and its analogues (Fischer et al., 2020; Fischer et al., 2016; Tyndall, 2018).

In addition to the changes in drug supply, the inadequate access to evidence-informed addiction interventions and broader societal attitudes and stigma (Basky, 2019) have contributed to an opioid crisis of historical proportions; in 2017, opioid-involved deaths reduced life expectancy at birth by 0.07 years (Canadian Centre for Substance Use and Addiction, [CCSA] 2021; Statistics Canada). Historically, the high hospitalization rates attributable to primarily prescription opioids were among older adults (65+); over the last ten years, hospitalizations due to opioid toxicity have been reported mainly among youth aged 15 and 24 and adults aged 25 to 44 (O'Connor et al., 2018).

OPIOID-RELATED DEATHS DURING THE COVID-19 PANDEMIC

The COVID-19 pandemic has worsened the already deadly public health crisis of opioid overdoses. The pandemic disrupted the provision of health services, counselling and mental health supports (Muhajarine et al., 2021) when individuals were under increased social and economic stress due to policies necessary to control the pandemic. It is no surprise then that opioid toxicity deaths rose during this time.

[2] In keeping with evidence-based practices in the area of harm reduction, this discussion paper will use the terms such as “overdose” and “poisoning” with the understanding that these terms carry with them the potential for stigmatization which can lead to individuals being blamed versus responsive public policy during a crisis (see for example: Collins, A. B., Bluthenthal, R. N., Boyd, J., & McNeil, R. (2018). Harnessing the language of overdose prevention to advance evidence-based responses to the opioid crisis. *International Journal of Drug Policy*, *55*, 77-79.)

Since April 2020 -- shortly after the onset of the pandemic in Canada -- and March 2021, there have been 6,946 apparent opioid toxicity deaths [AOTD][3] in this country[4], an 88% increase from the equivalent pre-pandemic period (3,691 deaths between April 2019 and March 2020). According to Public Health Canada (PHAC], approximately 20 AOTDs per day (1,772 in total) occurred between January and March 2021. Even during the pandemic, hospitals reported almost 6,000 opioid-related poisoning hospitalizations between April 2020 and March 2021, representing a 27% increase from the pre-pandemic numbers.

Fentanyl and fentanyl analogues were involved in 87% of accidental AOTDs between January and March 2021, and 90% involved a non-pharmaceutical opioid. During the same period, males aged 20-49 accounted for three-quarters of accidental AOTDs (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2021).

SASKATCHEWAN CONTEXT

Although more than 85% of all opioid toxicity deaths and 90% opioid-poisoning hospitalizations in 2020 in Canada occurred in British Columbia, Alberta and Ontario, the provinces that represent half of the Canadian population (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2021), Saskatchewan has not been spared from excessive death due to the opioids and polydrug use. Saskatchewan Coroners Service (September 2021) reported 303 confirmed drug toxicity deaths in 2020, an almost 300% increase from 2010. Between January 2021 and September 2021, there were 102 confirmed and 167 suspected drug toxicity deaths, with two-thirds of deaths related to fentanyl (SK Coroners Service, September 2021).

The opioid-related deaths have dominated public discussions due to their unprecedented health and social burden on society. Another factor that adds to the complexity of drug-related mortality in Saskatchewan and other prairie provinces is psychostimulants (cocaine, crack/cocaine, methamphetamines). The Saskatchewan Coroners Services report (September 2021) indicates that between 2014 and 2020, confirmed deaths related to combined drug toxicity (methamphetamine as one of the drugs) increased more than 110% (from 3 to 113 deaths).

[3] Apparent opioid toxicity death (AOTD): A death caused by intoxication/toxicity (poisoning) resulting from substance use, where one or more of the substances is an opioid, regardless of how it was obtained (e.g. illegally or through personal prescription). Other substances may also be involved (PHAC, 2021).

[4] PHAC data provide information from six provinces and territories (except Manitoba)

The implications of the changes in supply of illicit drugs and their availability are most profound among vulnerable, street-involved groups; this increase in stimulant consumption represents a "twin" or silent epidemic that warrants attention (Ciccarone, 2021; Jones et al., 2020; Fischer et al., 2021).

AT-RISK POPULATIONS

There are certain groups of people who are at higher risk for opioid use. A one-size-fits-most approach does not work for addressing harms caused by substance use. People who use substances alone are at higher risk for overdose, people who are long-term users are at higher risks for death related to chronic use. Deaths related to long-term use are not counted in the opioid mortality statistics.

The reasons for use differ, and the approach used to address risk factors must be taken into consideration. Indigenous peoples are over-represented within the mortality statistics. Reconciliation efforts and acknowledgement of the role colonialism plays in health inequities must be addressed to curb drug use (Lavalley, 2018). Those who have been involved in the criminal justice system, including those who are in the process of reintegration into their communities, are at risk for additional challenges with problematic substance use and the combined stigmatization of involvement with corrections (Canadian Centre on Substance Use and Addiction, 2017a).

The opioid crisis disproportionately appears in the trades, with over 19,000 deaths within Canada during the past five years. Organizational culture, risk of injuries, stress, and stigma have meant that many do not identify their risks or seek assistance (Wall, 2021). In general, young males under the age of 39 are at higher risk of opioid-involved deaths. In addition to people in the trades, this age group often includes street-involved youth and street entrenched adult drug users and recreational drug users, as well as those who are event-specific users, such as weekend use at parties (Canadian Centre on Substance Use and Addiction, 2017b; Carriere, Sanmartin & Garner, 2021). While statistics are not readily available, it is reasonable to assume that this is a key demographic to consider within Saskatchewan as well.

EVIDENCE-INFORMED RESPONSES TO THE OPIOID-RELATED HARMS

The almost two-decades-long opioid crisis in Canada has been addressed by a mix of unevenly implemented interventions that have been primarily reactive and with individually oriented medical (reversing overdoses with opioid antagonists) and criminal justice interventions (The Good Samaritan Law) rather than considering the wraparound services for the whole communities and populations (Fischer et al., 2020). The interventions usually involve opioid

agonist therapy with methadone or buprenorphine/naloxone and supervised drug consumption sites to reduce fatal outcomes of overdose and naloxone distribution for overdose rehearsal. Despite the best efforts of grassroots organizations and agencies, these services often struggle with funding and face public rejection and lack of political will to scale up their interventions.

Extant research suggests that effective responses to opioid-related deaths and harms need to be addressed across the continuum of care. Rather than heavily relying on one approach to recovery (e.i. abstinence-based models), a range of services, such as screening/assessment, community outreach, harm reduction and both pharmacological and psychosocial interventions are most effective at sustaining wellness and the quality of life when readily available and tailored to the complex needs of individuals who use opioids (Taha, 2018). For example, the benefits of the continuum of care model for individuals who use drugs intravenously has been demonstrated at both individual and community level. Needle exchange programs and opioid agonist treatment options improve health-related outcomes for individuals who use drugs and reduce healthcare costs associated with hospitalizations and mortality due to IDU-related complications (Tsybina et al., 2021).

FRAMING THE ISSUE OF EXCESSIVE OPIOID-INVOLVED OVERDOSES AND DEATHS AS A PUBLIC HEALTH CRISIS AND SOCIAL JUSTICE/EQUITY ISSUE

Excessive opioid-related mortality in Saskatchewan needs to be addressed from public health and social justice perspectives that employ the concept of harm reduction. While often thought of as needle exchange or safe injection sites, a harm reduction approach entails much more. Prohibition and abstinence do not work as an all-encompassing approach for every person. There needs to be a continuum of care where people and their changing needs can be met (Gomes & Vecchia, 2018), and there is recognition that specific behaviours and activities may continue to exist (Harm Reduction Coalition, 2017).

People with lived and living experience of drug use must be part of the decision making process when it comes to determining programming and policy decisions to ensure that they are relevant and that social and societal responses are included in response to substance use (Gill, 2006; Kolla, 2018; Nielsen & Dwhurst, 2006). Only by involving communities impacted by the opioid crisis can we ensure that policies and programming meet the current climate of those most affected by risk behaviours. Consistent efforts must be made to ensure that harms are not minimized or ignored, but rather that people are supported where they are at, and the safe choice becomes the easy choice (Harm Reduction Coalition, 2017).

Focusing on a continuum of care model ensures that there are wrap-around services for those who use illicit substances. Wrap around services often include social, and education supports, as

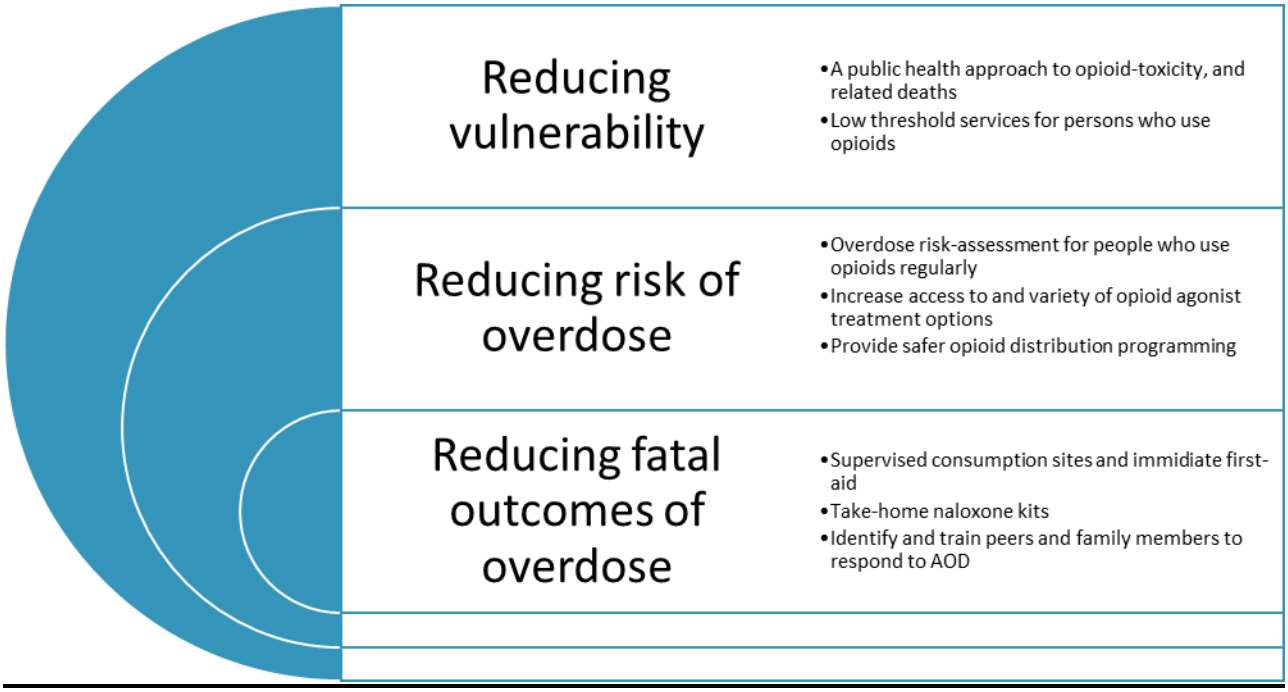
well as health supports that focus beyond a single outcome to what is needed for overall health of an individual, their community, and their support networks, both formal and informal. This approach has been shown to intervene in overdose events as well as improve the overarching health and wellbeing of people who use drugs (Kolla, 2018).

Interventions to reduce opioid-related deaths and mortality from polydrug use need to be applied as a comprehensive strategy that addresses specific populations at different levels of vulnerability to opioid toxicity and opioid-involved overdose deaths (Alho et al., 2020; EMCDDA, 2017).

THREE PILLARS OF INTERVENTIONS/STRATEGIES:

Many countries and jurisdictions recognize that the unique needs of different populations and communities require considering both immediate and long-term strategies to address both ongoing and emerging harms related to opioid toxicity (EMCDDA, 2017). Due to the complex and interrelated factors that contribute to harms associated with opioid toxicity, it is recommended that both risk and protective factors at both individual and community levels are considered. To demonstrate the need for a comprehensive approach to the opioid toxicity crisis, we suggest focusing on prevention of opioids overdose deaths at three levels/pillars (Figure 1).

Figure 1:



1. **<u>To reduce the vulnerability of individuals to opioid toxicity and opioid-involved deaths, the following measures should be considered:</u>**
   a. Tailored prevention, education and information sharing with the general public as well as specific populations about the opioid toxicity and risk of overdose or death:
      - Young males in the trades, transportation and construction industries were identified as at-risk populations for opioid-involved overdose and deaths (CCSA, 2017). We recommend that Saskatchewan-based employers in these industries start utilizing the evidence-informed ToolKit to address stigma related to opioid use, educate about the risks of overdose and present ready-to-use resources for employees (Available at https://www.ccsa.ca/substance-use-and-workplace-supporting-employers-and-employees-trades-toolkit)
      - Individuals involved in high-risk, long-term chronic use of opioids need access to low threshold services that would address their immediate needs. These include safer needle exchange programs with expanded hours and days of operations that provide more supports.
      - Individuals involved in the justice system should have access to treatment for opioid use disorders, whether through continuation or initiation of opioid agonist therapy, be educated about the risk of opioid toxicity, and have access to Naloxone.

2. **<u>To reduce the risk of opioid-involved overdose, the following measures are recommended:</u>**
   a. Prevention of the exposure to contaminated, illicit opioids:
      - Interventions/assessment to identify persons' increased risk of overdose and provide drug testing in safer drug consumption rooms.
      - Establish a "safer opioid distribution" program as a public health intervention addressing opioid toxicity in the community through the availability of injectable opioid pharmaceutical treatments such as diacetylmorphine or hydromorphone (Fischer et al., 2020). Expanding opioid interventions for individuals with chronic and severe opioid use through access to high-grade injectable opioids during the COVID - 19 public health social distancing prevented deaths from highly contaminated illicit opioid supply (Canadian Centre on Substance Use and Addiction, June 2020). Injection opioid agonist treatment is considered a "last resort" treatment for individuals who meet the criteria, such as intravenous drug use, be at risk for overdose and have a history of unsuccessful oral opioid agonist treatment.
   b. Increase of the availability and range of opioid agonist recovery interventions. WHO has called medication-assisted opioid treatment one of the most effective type of opioid treatment/ interventions.

- Expand Opioid Agonist Treatment [AOT] to Buprenorphine/Naloxone (Suboxone), Methadone, Slow-release oral Morphine (SROM) in larger cities and the north. Opioid Agonist Treatment reduces the risk of mortality substantially, and the retention in a drug treatment program is a protective factor against overdose and death. Increased availability of and access to AOT needs to be accompanied by the increased public awareness of its effectiveness by the government and local leadership. This will help reduce stigma associated with AOT that discourages people from seeking this form of treatment.
- Develop strategies for training, peer mentoring of more physicians in opioid agonist prescription regimes; address the general practitioners' resistance; consider stabilizing patients first in addiction-specific clinics before transferring them to primary care (Basky, 2019).

3. **To reduce fatal outcomes of overdose, we recommend scaling up the strategies for the opioid overdose reversal, namely:**
    - Access to supervised drug consumption rooms and immediate first-aid.
    - Ubiquitous and Low-Barrier access to Naloxone training and kits. WHO Guidelines on Community Management of Opioid Overdose (2014) strongly recommend using targeted Naloxone distribution to reverse opioid overdose. People who are likely to witness an opioid overdose should have access to Naloxone and be trained to administer it.
    - Know the Signs (Public Education and Outreach), such as publications from the Government of Canada (https://www.canada.ca/en/health-canada/services/publications/healthy-living/opioid-overdose-poster-for-communities.html

Key to the success of these interventions is the active engagement of and partnership with those communities at risk and those with lived experience. This is essential to ensure that interventions meet the specific needs of different populations in different contexts and that supports exists across a continuum of care. Designing and implementing interventions 'from the ground up' and with the active participation of the community being served is an essential element of increasing uptake, securing community support (legitimacy) and meeting the needs of those being served. It also provides a means to better understand best practices (what works in what context for which community) and creates better opportunities to transfer/adapt those practices to similar settings. This is admittedly a more time-consuming and complex process of policy design and implementation than a single province-wide approach, but it is also far more likely to have a greater impact on reducing opioid use and saving lives.

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About SPHERU

The Saskatchewan Population Health and Evaluation Research Unit (SPHERU) is a bi-university research centre located at both the University of Regina and the University of Saskatchewan. Established in 2000, SPHERU's mandate is to engage in interdisciplinary, community-based population health intervention research aimed at reducing health inequities across various populations in the province, including, but not limited to, those created by race, age, geography and socio-economic status. Its work is focused on children's health, rural health, Northern and Indigenous Health and the history of health inequality in the province and in recent years has also pursued a particular focus on senior's health and international maternal health.

The full history of SPHERU's research can be found at www.spheru.ca and on a special 20th anniversary website www.spheru20.ca that combines videos, animation, and testimonials to illustrate how SPHERU's two decades of collaboration and cross-sector partnerships bridged gaps between disciplines, organizations, and communities. SPHERU has catalyzed transformations through innovative research methods, engagement, knowledge creation, and intervention. Its researchers work directly with Saskatchewan communities, organizations, and community partners to make a real difference in the health of Saskatchewan people.

SASKATCHEWAN UNION OF NURSES

Discussion Paper

October 15, 2021

**The following is submitted in response to the community engagement presentation by the Saskatchewan Drug Task Force (DTF) and the request for discussion papers dated September 13, 2021. Given the high-level nature of the DTF presentation, the limited time allowed for submissions, and the pressures associated with the ongoing COVID-19 pandemic, the Saskatchewan Union of Nurses (SUN) is limiting itself to some broad feedback at this time. SUN looks forward to being engaged on an ongoing basis as the DTF develops its work.*

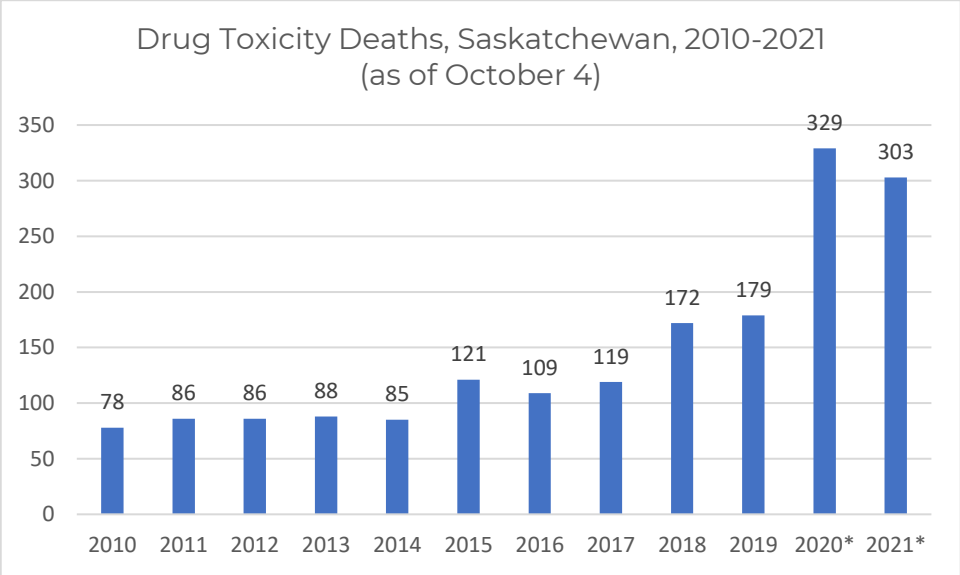
Positive Signs Amidst Crisis?

The provincial *Mental Health and Addictions Action Plan* (2014) contained no commitment to a coordinated provincial effort with respect to harm reduction. Indeed, the Action Plan explicitly disavowed a leading role for the provincial government in this area, and limited itself to vaguely encouraging municipalities, businesses, and community organizations to create partnerships to fill the void.[i]

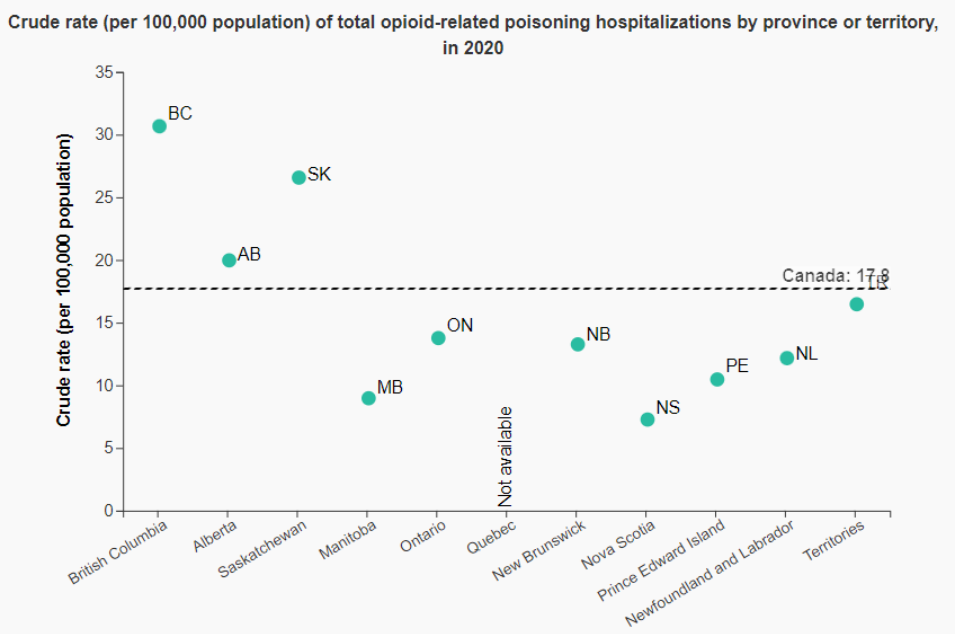
An analysis completed by the Canadian Harm Reduction Policy Project (CHARPP) of the Saskatchewan policy environment up to 2016 could note, alongside a description of a history of government opposition to harm reduction strategies, that "[t]he commitment to harm reduction in Saskatchewan policy documents has weakened over time."[ii]

The formation of an inter-sectoral Drug Task Force (DTF) to coordinate and monitor the Saskatchewan Government's response efforts to substance-related harms in our province is itself a positive step in a different direction. It is an initiative that could be poised to build in a meaningful way on the small but encouraging developments that have emerged in the face of recent public health crises – the HIV crisis, the opioid and overdose crises, and the COVID-19 crisis – and in response to tireless and committed advocacy by many people and organizations across the province.

These developments point to growing momentum behind a more evidence-based approach to substance-related harms and, one can hope, a fundamental rethinking of how we approach many related issues across government, the public services, and the community at large.



SOURCE: Saskatchewan Coroners Service. *Drug Toxicity Deaths, Saskatchewan, 2010 to 2021.* October 4, 2021. *2020 and 2021 figures include suspected drug toxicity deaths.



SOURCE: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants

Harm Reduction: Still the Poor Cousin?

The DTF's inclusion of Harm Reduction as a key Guiding Pillar for its work is a positive development. SUN is also encouraged by the commitment to Data Collection and Analysis. It is encouraging to see that increasing access to harm reduction services is among the DTF's priority Goals, and that some of the actions described as under development are consistent with a Harm Reduction approach.

The Saskatchewan Union of Nurses is concerned, however, that absent a more substantial and sustained provincial policy commitment and associated investments, Harm Reduction will remain the poor cousin of our approach to substance-related problems. In 2018-2019 – the latest year for which estimates are publicly available – the provincial government spent just $667,000 through the former health authorities to support harm reduction programs.[iii]

We believe the work of the DTF must place the principles and approaches of Harm Reduction more clearly at the centre of the strategy than they have hitherto been and resist the temptation to treat Harm Reduction as in any way incompatible or in conflict with the goals of prevention and treatment/recovery.

Harm Reduction: Central to a Comprehensive Health Approach

One of the key guiding principles of ethical nursing practice is to promote the health and well-being of individuals, families and communities in a non-discriminatory way that respects the human rights, dignity and autonomy of the people who receive nursing care. Another key principle of ethical nursing practice is that it should be evidence-based. Nursing professional and ethical standards are consistent with the principles and approaches of Harm Reduction. It is not surprising, then, that nurses and nursing organizations have been and continue to be key advocates.[iv]

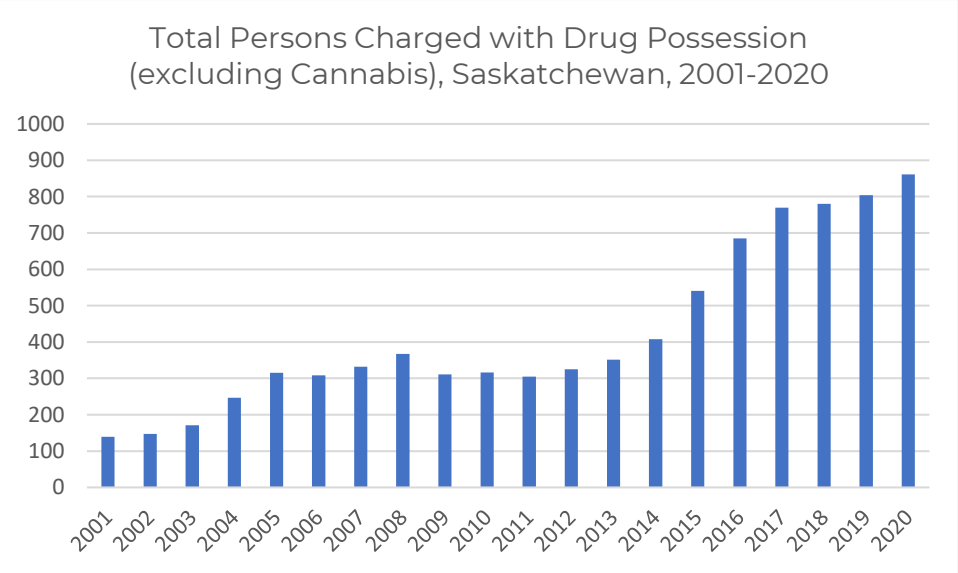
Offering non-discriminatory services to people who use drugs, with the aim of minimizing the adverse consequences of substance use for them and their communities, is not in conflict with providing comprehensive treatment. Harm reduction services offered in a non-discriminatory way have intrinsic value. As part of a comprehensive approach, they can not only reduce adverse health and social consequences of substance use but also facilitate access to health care and other vital services and encourage uptake to high-quality treatment programs when and where those are available and appropriate.[v]

Harm Reduction: Time for a Public Health Approach to Drugs

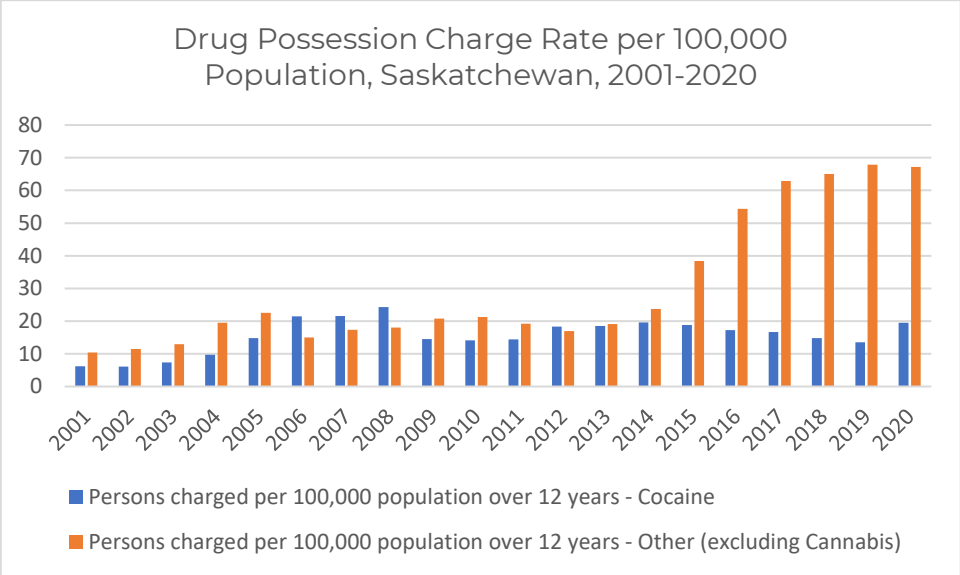
Principles central to a Harm Reduction approach, and consistent with a nursing approach – pragmatism, humanism, a focus on harms, evidence-based assessment of effectiveness, balancing of costs and benefits – can and should help to inform a more fundamental re-think of drug policy more broadly. It is SUN's sincere hope that the work of the DTF can contribute in a meaningful way to such a fundamental re-think.

More than 25 years ago the *American Journal of Public Health* published a set of recommendations aimed at re-balancing drug policy away from a moralistic and repressive focus on stigmatization, prohibition, and criminalization, and towards a public health approach:

> The principal goal for drug policy should instead be to reduce harms to society arising from the production, consumption, and control of drugs. Total harm (to users and the rest of society) can be expressed as the product of the total use and the average harm per unit of use and thus can be lowered by reducing either component. Attention has been focused on the first; greater attention to the second would be beneficial ... Based on experience since 1985, the rhetorical and policy-oriented emphasis on making drug use less acceptable and drugs less available, as well as the focus on drug prevalence as the dominant indicator of program success, has probably outlived its usefulness.[vi]



SOURCE: Statistics Canada 35-10-0177-01



SOURCE: Statistics Canada 35-10-0177-01

Despite growing momentum – and evidence of effectiveness – behind a public health approach to drugs, policy largely continues to be underpinned by a moralistic and prohibitionist stance. There is a growing realization that this policy approach must be considered an expensive failure on its on terms, and itself a significant source of harm.[vii]

According to the Canadian Public Health Association, these are just some of the harmful consequences of criminalization:

- Crowding and slowing of the criminal justice system as a result of the prosecution of drug-related offences for non-violent crimes;
- Enforcement activities and stigmatization that drive those who use illegal substances away from prevention and care services;
- Opportunity costs of allocating resources into law enforcement, judicial and correctional/penal approaches with consequent scarcity of resources for public health and social development approaches.[viii]

Criminalization also "trickles down" to contribute directly to health inequities and to create real barriers to day-to-day ethical nursing practice. As the Canadian Nurses Association has observed with respect to Harm Reduction – but this applies more broadly

in many areas of the healthcare system – the patchwork of policies and strategies related to drugs and problematic substance use creates challenges:

> As the work of nurses is often governed by organizational and provincial policies, this discrepancy can be both a challenge and a barrier as nurses strive to deliver the most appropriate, evidence-informed programs and interventions in harm reduction. It has created a policy schism in which nurses in practice, administration and education are caught between law enforcement and harm reduction approaches. Drug policy is one, albeit an important, aspect of addressing the root causes of health inequities.[ix]

In 2020 even the Canadian Association of Police Chiefs – in response to the report of their Special Purpose Committee – recognized that problematic substance use is a public health issue, and that decriminalization of simple possession is an effective way to reduce the public health and public safety harms associated with substance use. The report acknowledged that "[t]he compelling case for transformative change has been made by public health officials…" and concluded:

> We must adopt new and innovative approaches if we are going to disrupt the current trend of drug overdoses impacting communities across Canada. Merely arresting individuals for simple possession of illicit drugs has proven to be ineffective. Research from other countries who have boldly chosen to take a health rather than an enforcement-based approach to problematic drug use have demonstrated positive results. […] Health is best positioned to address problematic substance use and not the police.[x]

Developing new and innovative approaches to deliver transformative change in this area is a complex and controversial undertaking. There are many difficult issues related to the extent and nature of the legal, policy and practical alternatives to criminalization that can and should be pursued, the nature and mix of *de facto* and *de jure* mechanisms, and the appropriate roles to be played by different sectors and actors across the range of human services, for example.[xi]

Complexity and controversy cannot become an excuse for indifference or inaction. The cascading public health crises and human tragedies that we have faced and continue to face present us with an opportunity, and a responsibility, to be bold.

As part of its strategic leadership and oversight role, an intersectoral forum such as the Drug Task Force may be well positioned to begin a dialogue on the "big picture" elements of drug policy, but also to strategize on concrete ways in which barriers created by policies and practices across sectors can be aligned to support a more effective and more robust health-focused response to problematic substance use, one in which enhanced Harm Reduction services and a commitment to addressing the social determinants of health must play key roles.

[i] *Working Together for Change: A 10 Year Mental Health and Addictions Action Plan.* December 1, 2014.
[ii] Canadian Harm Reduction Policy Project. 2017. *Saskatchewan Policy Analysis Case Study.* August. Available at: https://crismprairies.ca/wp-content/uploads/2018/06/Saskatchewan.pdf
[iii] Population Health Branch, Ministry of Health. 2019. *Harm Reduction Programs and Services in Saskatchewan:* p.4.
[iv] Canadian Nurses Association. 2017. *Harm Reduction and Illicit Substance Use: Implications for Nursing*. Ottawa: CNA.
[v] United Nations Office on Drugs and Crime. 2009. *Reducing the Adverse Health and Social Consequences of Drug Abuse: A Comprehensive Approach.* New York: UNODC.
[vi] Quoted in G. Alan Marlatt. 1996. 'Harm Reduction: Come as You Are,' *Addictive Behaviors*, 21(6): p. 779-780.
[vii] Boyd, S.C., C.J. Carter, and J. MacPherson. 2016. *More Harm Than Good: Drug Policy in Canada.* Winnipeg: Fernwood.
[viii] Canadian Public Health Association. 2017. *Decriminalization of Personal Use of Psychoactive Substances*. Ottawa: CPHA.
[ix] Canadian Nurses Association. 2017. *Harm Reduction and Illicit Substance Use: Implications for Nursing*. Ottawa: CNA: p.30.
[x] Special Purpose Committee on the Decriminalization of Illicit Drugs. 2020. *Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety and Policing.* Kanata: CACP: p.
[xi] See for example: Centre for Addiction and Mental Health. 2021. *Statement on the Decriminalization of Substance Use.* Toronto: CAMH; Jesseman, R. and D. Payer. 2018. *Decriminalization: Options and Evidence.* Ottawa: Canadian Centre on Substance Use and Addiction; Carter, C., and D. MacPherson. 2013. *Getting to Tomorrow: A Report on Canadian Drug Policy.* Vancouver: Canadian Drug Policy Coalition.