Policy Brief Submitted to the KFL&A Public Health Board
April 26, 2021
From the Integrated Care Hub - Kingston

BACKGROUND

In March of 2019, the City of Kingston adopted the Canada-wide lockdown and social distancing public health measures to stem the spread of COVID-19, resulting in many health and social service agencies not being able to provide support at regular capacity, nor see people in person. Some services moved to online platforms, but many of our citizens have no internet access. Drop-ins, support groups, food programs and other places where people used to congregate had to shut their doors, even public libraries with free internet access were closed. Shelter capacity was reduced, leading to tensions, uncertainty, and feelings of displacement among our homeless population, which continue. While shelters need to reduce their capacity to maintain social distancing protocols, doing so further isolates, and fails to meet the needs of those who use substances. In a drug-poisoning crisis, it is safest to be together, but in a global pandemic, it is safest to be apart.

The needs of substance users are often misunderstood, but social distancing measures hammered home the urgent need to provide help to those who experience chronic homelessness and use substances. The Integrated Care Hub (ICH) addresses three intersections of crisis: the COVID-19 pandemic, a complex housing crisis, and a drug-poisoning crisis. It was created by and is managed by three experienced front-line harm reduction advocates from the Street Health Centre and HIV/AIDS Regional Services. As the rise of variants to the COVID-19 virus have led to further surges and subsequent lockdowns, it is essential that the ICH remain open to serve the needs of Kingston's most marginalized citizens.

PROBLEM-SOLVING

The drug poisoning crisis means that people who are using substances are dying tragically and at a terrifying rate due to a toxic drug supply with no respite from criminalization, demonization and stigmatization. From the Opiate Mortality Surveillance Report (June/19), 73.6 percent of fatal overdoses occurred among people living in a private dwelling and 9.8 percent occurred among people experiencing homelessness. Nearly half (48.6%) of deceased persons were alone at the time of incident. The number of opioid-related deaths increased quickly after the state of emergency declaration. Overall, there was a 38.2 % increase in opioid-related deaths in the first 15 weeks of the COVID-19 pandemic. According to the Interactive Opioid Tool by Public Health Ontario, **KFL&A experiences a 21.5 % higher rate than provincial average** of opioid-related deaths. The ICH has proven to be a life-saving program based on the number of overdoses responded to and reversed. In December 2020, the ICH responded to and reversed 70 overdoses on property. In January 2021, the Consumption and Treatment Service responded to more overdoses than all of 2018 and 2019 combined.

ICH Residents

In order to know how to meet someone's needs, we need to understand how their needs were not met to begin with, or were disrupted along the way. It is well known that many people experiencing chronic homelessness have experienced complex and chronic trauma histories that most often result in self-defeating patterns of behaviour. For example, we know that people who have an Adverse Childhood Experience Score of 4+, are 1,000 times more likely to inject substances. It is also important to acknowledge that people are experiencing significant systemic and structural violence within our community. The fact that people on income assistance like Ontario Works and ODSP are not able to access housing due to unrealistic rental rates is one example of systemic and structural violence. We also know that people who are a part of BIPOC, and 2SLGBTQ+ communities and women, experience significant intersectional oppression as well.

People who have complex, concurrent disorders (mental health and substance use) are often chronically homeless, disconnected from familial relationships, suffer with low self-esteem and little self-worth, live in a state of toxic stress,

experience food insecurity, likely have higher rates of traumatic brain injuries, live with cognitive disabilities, and are often seen as non-productive and thus, not-valued members of our community. If a human being's basic needs are met, they are going to behave in predictable ways. We also know that if a person's basic needs are not met, they are going to behave in different, but predictable ways. "It is not our behaviour that defines our nature, it's our needs that define our nature. The behaviour reflects the degree to which those needs are met or they are not met." (Gabor Mate, 2008)

When governments make difficult decisions like shutting down the economy in order to curb the spread of COVID-19, they consult with experts: epidemiologists, respirologists, health systems managers, etc. Our residents at the ICH are the experts about their lives, and what they need to stay alive, and hopefully one day, claim their old lives back. They all have memories of what life was like before they were homeless. The ICH has just completed a rapid needs assessment about people who frequent The Hub and use crystal meth and/or opiates. We hope above all, that the information gathered will guide the development of effective responses and drug policy to support people who use crystal meth and opiates, and prevent overdose. A full report will be available before the end of May, 2021. What follows is a sample.

FINDINGS

Demographics

32 individuals aged 18 and over participated in one hour semi-structured interviews conducted by ICH managers, team leads and program coordinator (Feb 1-April 14, 2021). One of the limitations is a smaller female sample of 11 as compared to 21 males. This speaks to the difficulty of reaching women under 30 who use substances, a hidden population. In terms of self identified ethnicity, 47 percent of males were Caucasian and 36 percent of females; 33 percent of males had mixed Indigenous ancestry and 33 percent of females; 19 percent were of males and 18 percent of females were Indigenous, and one female self-identified as being of mixed African decent. This highlights the over representation of Indigenous people in the homeless population. Fifty-two percent of males completed high school, while only one female did (half had dropped out by grade 10). From a developmental health lens, it is important to note that 56 percent of participants cited having a learning disability that impaired their schooling.

Mental health and trauma have been and continue to be significant barriers to wellness in the ICH community. Ninety five percent of males and 91 percent of females indicated having had multiple mental health diagnoses. Five of 11 females lost a parent or closed loved one by age twenty, one male lost his grandmother and father in the same year and he dropped out of college, one male lost his mother to overdose at the age of 18, and 3 males have not spoken to their family members in over 20 years.

Only 24 percent of males and 45 percent of females indicated having a **family doctor.** Six males cited having had negative experiences in the health care sector and another three avoid care altogether. In the past year, males made an average of 3.7 **trips to hospital**, females 4.9. Of a total of **134 trips to hospital**, mental health issues accounted for 38 trips, overdose 22, physical issues 18, and infections 8 (and another 2 for endocarditis).

The evidence indicates that **safe supply** would save lives and visits to hospital. On average, males indicated they knew of 50 people who had overdosed, females an average of 57. Males had lost an average of 18 people close to them to death by overdose, females an average of 20. An average of 10 males had overdosed in the past year, 2.8 females. Of these, 53 percent had been revived by friends, 34 percent by ICH staff, 28 percent by CTS staff, 19 percent by emergency responders, 9 percent by strangers, and only one person had been resuscitated in hospital. This indicates that it is the community itself that is responding to overdose, an incredibly **traumatic** phenomenon that leaves them in constant worry. As one respondent described what safe supply could do: ""It would change my life. I could be productive, not chase dope, not die… just live life!" Staff at the ICH and CTS are also lifesaving, which calls for the addition of self-care and **counselling** for them in these traumatic roles, in the same way that we provide supports to first responders.

Also significant is the evidence around **substances used** and **links to overdose**. People using crystal meth daily (and marijuana to sleep) overdosed 17 times. People using a combination of crystal meth and opioids (to sleep) daily, or binging on them, overdosed 59 times. People using Fentanyl daily (and crystal meth to 'get things done') overdosed 134 times. While the prevalence of crystal meth as first drug of choice for daily use (44%) is only slightly higher than that of Fentanyl (37.5%), the risk of overdose is almost double, and Fentanyl is tainting the crystal meth supply. If these people could be treated for their physical and mental pain through pharmacology, and crystal users having access to clean product and marijuana for sleeping, the overdose crisis would be dramatically reduced.

Ninety percent of males had been incarcerated, of which 57 percent indicated charges were drug related. For females, 73 percent had been incarcerated and 64 percent indicated charges were drug related. Early incarceration due to drug use dramatically changed peoples lives. When discussing the prospect of decriminalization of street drugs for personal use, a middle aged man said: "I don't think I would be in the situation I am in, if this had always been a thing." A forty-ish female said" "The first time I ever went to jail was because of drugs – I was young and it [messed] me up."

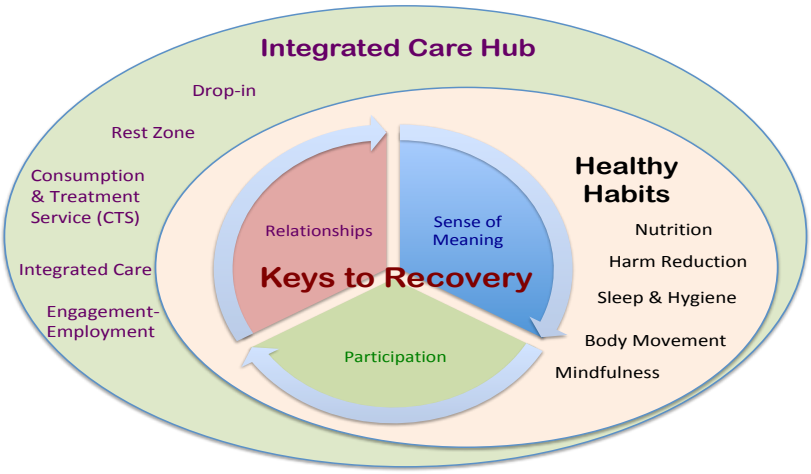
The following is a sample of what respondents said when asked what they wanted the KFL&A community to know:

- "Housing… affordable housing – not renting a room from a slumlord that's not fit to live in. You leave and come home and your door is kicked in. I can't live like that or have my girlfriend in a place like that or a family in a place like that. If I could find housing before my child is born then I know I could keep our child." (30-ish Male)
- "Listen, learn… who knows, you might actually like me. Just a reminder, you are one shitty day away from being me." (20-ish Male).
- We should support each other, forming a community or organization, learning programs like technology, learning, living, giving people a fresh start.(20ish Male)
- "I just want to see the stigma lifted! People think we are dirt balls and it is sickening" (30ish Male)
- Know that we need personal boundaries (space), where we can own our own space, because we are always under attack (30ish Male).
- "We are not all shady. There are some really amazing people. We just need a hand up, not a hand out!" (30ish Female)
- "… really help people, don't just pass by and act like we aren't real people. I'm a real person, I have feelings, real feelings, and they hurt." (30ish Female)
- "The shelter system could involve the community more in understanding and helping vulnerable people. Embrace one another." (middle-aged woman)
- "We are doing a really, really good job here at the hub. Our hearts are involved in this and we are really appreciative" (middle-aged female)

Where we are now

We need to be intentional and informed in creating supportive housing programs for people who use substances to ensure proper Overdose Prevention Supports are in place. Moving forward, we believe that we need to shift mental health service delivery to an integrated, wrap-around recovery care model geared to meet the unique needs of the people we serve. This means we believe we need to shift away from cognitive-oriented therapies as a first response. Instead, our goal should be getting these people to a level of stabilization where they can think beyond daily - or hourly - survival. We can help them achieve stabilization through occupational therapy principles and a mental health recovery approach that highlights the transitions from a life focused on illness and disability to one focused on action and participation.

The ICH has also created a Nutrition Strategy to support stabilization based on gut microbiome health research and the positive effects that gut microbiome can have on mental health outcomes. Food is foundational to health, and can significantly improve the brains and bodies of the people we serve. Teaching people how and what to eat is life-skills programming that can be used as a harm reduction tool to mitigate side-effects of chronic substance use and stress on



the body. This Nutrition Strategy is geared to stabilize blood sugar, increase dopamine, increase neurotransmitters, and thereby regulate mood, decrease inflammation, and benefit gut microbiome health resulting in better blood-brain-barrier permeability.

RECOMMENDATIONS

1) More private spaces (e.g., couples), capacity, individual rooms
2) On-site primary care & referrals
   - Infections, cysts, endocarditis
   - Pain management
   - Address head trauma, broken bones
3) Systemic changes are needed
   - Safe Supply
   - Decriminalization
4) Programs need to align with a more person-centred philosophy;
5) Services need to be more relationship-focused and violence & trauma-informed;
6) Increased supports that engage people in meaningful activity and support life skills; and
7) ***Effective*** community integration supports are needed to prevent ongoing homelessness.

We envision working with community partners to develop a fully integrated mental health recovery approach specific to the people we serve at the ICH: people with cognitive disabilities, brain injury, complex mental health and substance use issues. This recovery model includes meaningful engagement/employment opportunities using an anti-oppression approach with a nutrition strategy created to address substance use and mental health side effects.

We need time to develop new pathways to care for this population, and specialized assessment and to better understand what kind of human resources and training is needed to serve them best. What we hope is that our work at the Integrated Care Hub can serve as a formal pilot project, so we can explore new care pathways with community partners; gain empirical evidence around the effectiveness of the integrated care model; and develop a best practice model that could be used in other jurisdictions, sharing our experiences.

We believe that our integrated care approach will lead to greater rates of recovery from mental health and substance use issues, and break cycles of inter-generational poverty and trauma. This will lead to a reduction in chronic homelessness in our community, which, in turn, leads to significantly reduced costs to our health care, criminal justice, and social welfare systems. One cannot put a price on the social costs of not acting to help these people, our most marginalized citizens because they are someone's mother, daughter, grandfather, brother. Their lot in life is greatly impacted by the structures in place. To counter this systemic marginalization, there must be a shared accountability for wellness. The ICH evolved out of the pandemic, and we think we have an opportunity to make this a legacy that our community can be proud of.