Integrated Care Hub Rapid Needs Assessment

Synopsis of Recommendations

Working Document V.2 September 8, 2021

Kingston, Ontario is experiencing a drug poisoning crisis and a homelessness crisis during a global pandemic. In such dangerous times, it is not wise to make assumptions based on our pre-COVID knowledge. We believe that the people who frequent the Integrated Care Hub (ICH) – our stakeholders – know best what they are experiencing and what they need. A rapid needs assessment about people who frequent the ICH and use crystal meth and/or opiates was undertaken, and a detailed report generated. 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. It provides a wealth of information and suggestions from the stakeholders interviewed.

This document serves as a synopsis of new assumptions gleaned from the needs assessment and proposes some recommendations to begin addressing them. We heard our stakeholders, and we now have some new ideas about how to help them to help themselves. This synopsis provides a start to mapping how community members and organizations can contribute to health and social justice for people who use substances in KFL&A. **We hope to achieve a commitment from all health care and service agencies within the KFL & A Region – housing, policing, hospital and community services – to work together to address these recommendations.**

Before we attempt to modify programming and operations, it is imperative that we first agree on an ethos that will guide our work, reflect on our positionality and privilege, and take an ethical stance around collective values and the six assumptions that arise from them, which are listed below.

Assumption #1 – Health and Social Justice for all citizens of KFL & A is the goal we are collectively striving for as service providers, friends and family members, neighbours, and society at large. The COVID-19 pandemic exposed how important stable housing is to health, but the overdose epidemic worsened, and continues to rob people of their lives every day, people 'who have people that care about them'. The Shadow Epidemic is incessant.

Implications

- People who are homeless and/or use substances are valued as much as other citizens, recognizing that their challenges are not just the result of individual choices, but of environmental and societal forces as well.
- People who are homeless and/or use substances are worthy of respect for their resilience and agency despite living in very challenging circumstances.
- We recognize that stakeholders at the ICH are the experts about their own lives and should be engaged in dialogue on the development of policy and of programming, and their evaluation.
- The tax dollars spent on policing, judicial and corrections have not curbed substance use, associated street crime, and the human suffering it entails. There must be a better way.

Assumption #2 – That stigma against people who are homeless and/or use substances is often perpetrated in most aspects of society (policy makers, health and social service providers, friends and family members, neighbours, and society at large). Though difficult to do, it is important that we acknowledge this within ourselves, and the harm that has been done in our institutions and communities, knowing we can do better by being accepting of what we have heard from stakeholders of the ICH.

Implications

- We must engage in self-reflection as to how our biases impact the lives of people who are homeless and/or use substances, as well as the organizations we work for and/or are affiliated with in an effort to identify and address stigma in all of its forms.
- Group discussions about moral injury and anti-oppressive approaches could start some of these challenging conversations in a way that is safe and constructive, and provides a common de-stigmatizing language, because language matters.
- We need to build empathy for people who use substances, that their plight is not one of individual failure, but that our systems have not been able to meet their needs and individual contexts, an issue we are attempting to address using the advice from our stakeholders at the ICH, and emerging best practices in science, medicine, and social science.
- Language is important: words like disorder, illness, and issues are individualizing and stigmatizing. We use the word challenges.
- We need to provide specialized training to front-line staff, managers and decisions makers around reflexivity, anti-oppression approaches and the prevention of moral injury.
- People who serve marginalized populations are often subject to potentially morally injurious events when they witness stigma or cannot get the help that people need because of policies and service restrictions, for example. They too need supports for their mental, emotional and spiritual well-being, similarly to First Responders.

Assumption #3 – Many of those served at the ICH are people with complex conditions – cognitive, mental health and substance use challenges – who may or may not be homeless (e.g., they could be couch surfing or surviving outside of the homeless shelter system, but their housing is not stable). We refer to these complex conditions as "tri-diagnosis[1]."

Implications

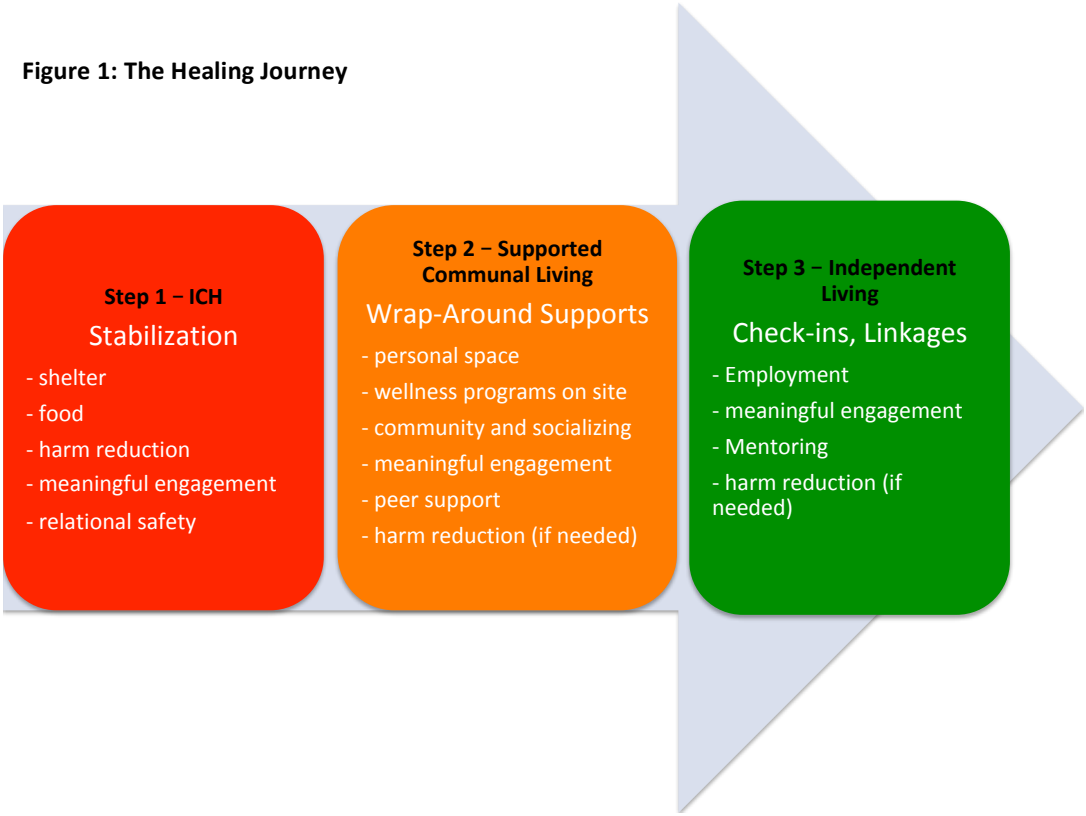
- There are significant chronic health challenges as well as mental health and addictions challenges that need to be addressed. Head injury, infections, chronic pain, and PTSD (especially females) are pervasive within this population, and inter-related.
- A linear model of recovery and associated health outcomes is not practical for this population who lack stability in their lives (housing, employment, mood, caring relationships, etc.), where day-to-day survival is what drives them. They need to first experience a feeling of stability and safety ("consistency and predictability across time" – Vikki Reynolds) before they can begin the difficult work of dealing with the roots of their addiction (ACES, intergenerational trauma, etc.).
- A fully integrated whole person healing-centered approach specific to stakeholders we serve that addresses the many steps they will take (and likely re-take) on their healing journeys.

[1] See http://www.community-networks.ca/wp-content/uploads/2015/11/survey-report-oct-15v.pdf

- Housing and meaningful engagement/employment are ultimately involved within the healing journey to wellness and independence but must be low barrier at the outset given the prevalence of cognitive and mental health challenges within the population of people who are experiencing homelessness and/or who use substances.
- For people who are experiencing homelessness and/or who use substances, sobriety should not be the first goal to recovery. Most of the ICH stakeholders interviewed indicated they would continue to use substances even when housed. Thus, harm reduction practices must be an on-going feature in wellness programming for this population. Most indicated that a safe supply program would allow them to integrate back into employment without the constant fear of overdose or having to engage in street crime for income.
- There are significant structural barriers to realizing a healing centred engagement approach to wellness (which takes time) that need to be identified and addressed, given the siloed nature of government funded services and the precarious funding of not-for-profits.

Assumption #4 – The people served at the ICH are often disconnected from their biological family and the people they knew before they became street-involved. This is either forcibly because those relationships deteriorated under the strain of living with someone with mental health and addictions challenges, or by choice as the person afflicted attempts to shield their loved ones from the pain and afflictions they suffer. Additionally, intergenerational trauma is often a source of pain. Rather, their social support net often consists of people in similar situations as they are – people in day-to-day survival mode – who nonetheless look out for each other, especially as it pertains to the threat of overdose.

Figure 1: The Healing Journey



Implications

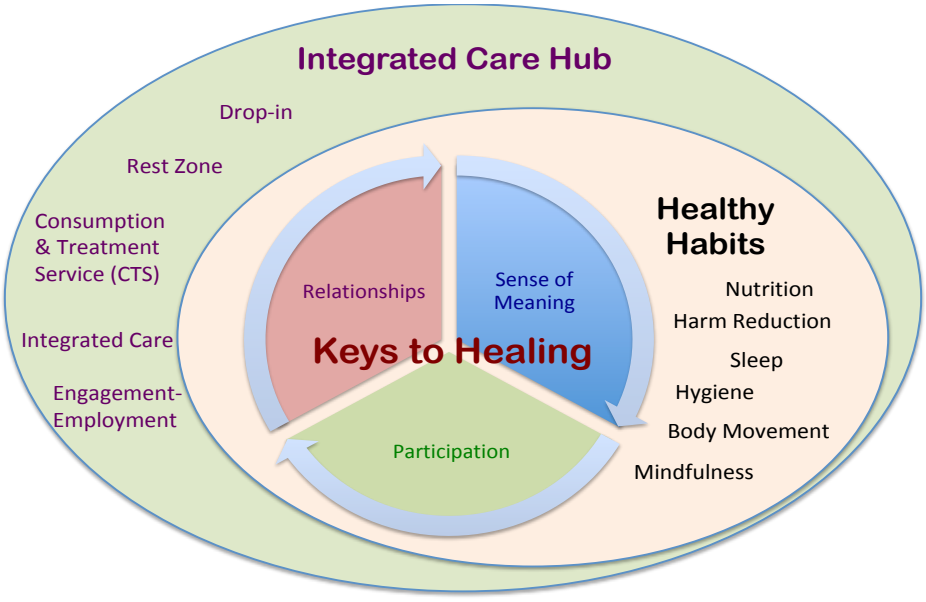
- In the initial stages of the healing journey, people need their community at the ICH.
- Later, the healing centred engagement model should provide opportunities for people to contribute and reintegrate into family and community before being expected to live independently, as many need to redevelop a social safety net, and rebuild their identity and self-confidence.

Assumption #5 – The people served at the ICH want to work, to contribute to society, to reconnect with their children, and remember a life before using substances and/or homelessness. Almost all are looking for a second chance, what they describe as "a hand up, not a handout". However, survival on the streets has had a significant impact on their cognitive, physical and mental health. One participant suggested if we knew what they were good at, and what they liked, we could develop customized programming to help them build on their gifts.

Implications

- We need time to develop new pathways to care for people with tri-diagnosis and specialized assessment.
- We need to better understand what kind of human resources and training are needed to serve them best.
- We need to explore ways to engage ICH stakeholders in social entrepreneurship and trades.

Figure 2: ICH's Integrated Care Model



With the help of community health and social service partners, is hoped that the work at the Integrated Care Hub can serve as a formal pilot project, so new care pathways can be explored with community partners, empirical evidence around the effectiveness of the integrated care model can be collected, to lead to the development of a best practice model that could be used in other jurisdictions through sharing our experiences.

Assumption #6 – There is a lack of decent, safe, affordable housing in Kingston, particularly for individuals living in low-income, and/or dealing with physical, cognitive, mental health and/or substance use challenges.

Implications

- Like the Marshall and colleagues "Beyond Surviving" report (2021) on homelessness in Kingston, similar issues and subsequent recommendations are raised by the ICH's needs assessment. We support the 9 recommendations of the Marshall and colleagues report, adding two more (see the Housing and Supports section on page 7).

What follows is a synopsis of recommendations based on the results of the rapid needs assessment.

#1. Anti-Stigma Training and Awareness Strategy

How we value people with tri-diagnosis seeps into institutions and curricula, leading to stigmatization, exclusion, and marginalization.

Recommendations:

1.1. Use the testimonies of ICH stakeholders to inform an anti-stigma strategy across the KFL&A region
- Partner with the Community Drug Strategy's Stigma Subcommittee
- Articulate how prohibition policy and practice is not helping the overdose epidemic or keeping citizens safe from the dangers of substance use

1.2. Building compassion on the front line: quick **resources** that organizations can provide to their managers and staff, in hospitals and community
- The Best Explanation of Addiction I've Ever Heard – Dr. Gabor Maté – Bing video
- Johann Hari: Everything you think you know about addiction is wrong | TED Talk
- Nadine Burke Harris: How childhood trauma affects health across a lifetime | TED Talk

1.3. Develop a long-term strategy for curriculum and training based on anti-oppression theories and dialogical action
- A coordinated commitment by all social service organizations to commit to not tolerating discrimination against people who use substances. This includes a commitment by leadership for education/training to build compassion for people with mental health and substance use challenges who may or may not be experiencing homelessness
- **Resource:** *Pedagogy of the Oppressed*, a short book by educator, Paolo Freire, 1970 https://envs.ucsc.edu/internships/internship-readings/freire-pedagogy-of-the-oppressed.pdf

#2. Harm Reduction, Decriminalization and In-patient Rehabilitation

Harm reduction alone in community mental health settings will not be sufficient to move people forward on their healing journeys, but it will help ensure they are not dying of drug poisoning.

Recommendations:

2.1. Increase access to CTS

2.2. Healing journey: provide both abstinence-only and harm reduction approaches

2.3. Publicly funded in-patient rehabilitation and stabilization

2.4. Decriminalization of substances for personal use (build on the support received from the Board of Public Health and Municipalities of KFL&A)

2.5. Safe-supply pilot at the ICH (crystal meth, fentanyl, medical marijuana) using a medical/prescription approach to drug regulation

#3. Preventing Moral Injury (Unrepaired Shame)

Moral injury is described as a from of psychological difficulty, an interpersonal crisis, or a spiritual wound resulting from learning about, bearing witness to, failing to prevent, being a victim of or perpetrating any event that transgresses one's subjective moral standards or deeply held personal beliefs. It can also result from the betrayal of justice by a person of authority (Nazarov, 2020). The risk of experiencing morally injurious events by stakeholders is related to stigma, service interruptions, street life, and trying to take care of their community during the housing/drug poisoning/COVID-19 crisis. For workers and management serving them, morally injurious events are related to reversing and witnessing overdoses, and not being able to get people the help they need. Moral injury is an injury of the heart and/or soul when the mind is unable to find meaning around situations of injustice. It can involve feelings of guilt, shame, and anger, which can also lead to shaming and blaming behaviours as a defense mechanism.

Recommendations:

3.1. Anti-stigma training and awareness

3.2. Check-ins around potentially morally injurious events

3.3. Grief counseling for the ICH community, staff and management

3.4. Counseling for front line workers around exposure to morally injurious events and the debilitating effects of burnout

- **Resources**:
    - Nazarov, A. (2020). "What is moral Injury? An Overview." 2020 CIMVHR Symposium Series - Unpacking Moral Injury: Current Understanding, Gaps, and Future Directions, October 29, sourced from https://symposium-series.cimvhr.ca/en/2020/moral-injury
    - Understanding Moral Injury on the front lines of a pandemic: https://youtu.be/AybMPLVbtvg
    - Moral Stress Amongst Healthcare Workers during COVID-19: A Guide to Moral Injury, sourced from https://www.moralinjuryguide.ca/wp-content/uploads/2020/07/Moral-Injury-Guide.pdf
    - Brené Brown, Listening to Shame and Daring Greatly: https://youtu.be/psN1DORYYV0
    - The Zone of Fabulousness, Vikki Reynolds: https://www.youtube.com/watch?v=XLmxb2sc_Nc

#4. Healing Centred Engagement (HCE) and Wellness Services and Programming

People who frequent the ICH are likely to suffer the 'tri-diagnosis' of cognitive, mental health and substance use challenges. Their psychological trauma also manifests physically. Typically, the first care approach to such complex conditions is cognitive: to provide substance use and addiction counselling and

treatment services. That needs to change (Luteijn et al., 2020[2]; McQuaid et al., 2018[3]). Moving from a perpetual state of surviving to thriving is a complex journey, requiring addiction medicine, psychiatry, occupational therapy and disability care professionals to join forces, also culture, spirituality, civic action and community.

Recommendations:

4.1. Nutrition Strategy - The ICH needs stable funding for the implementation of its Nutrition Strategy to support stabilization based on gut microbiome health research and positive effects on mental health outcomes.

- **Resource**: Impact of Gut Health for Mental Health and Relapse Prevention https://www.youtube.com/watch?v=VJLR1uzEXq8

4.2. Expanding medical care and on-site primary care: permit quick and on-going treatment of infections, cysts, and endocarditis that require safe administration of antibiotics; pain management for people with physical disabilities; pathways for head trauma; broken bones assessed for referral.

- **Resource**: Comprehensive Person-Centred Pain Management: Common Themes and the Way Forward: https://symposium-series.cimvhr.ca/video/chronic-pain.mp4

4.3. Integrated Care within a bio-psycho-social-spiritual community-based approach (Jaiswal et L, 2020[4]; McQuaid et al., 2018) emphasizing belonging and enhancing social connections, including reconciliation-based family programming.

- **Resource**: The New Paradigm: Healing Centered Engagement (Ginwight, 2020), https://youtu.be/MKUNtOUQuFM

4.4. Occupational therapy and the development of personalized care plans through dialogical action, building up people's potential, hope and optimism about the future.

- **Resource**: Canadian Association of Occupational Therapists' 2019 Conference on Addressing Addiction, https://caot.ca/document/6886/PIF%20Report_Addressing%20Addiction_2019.pdf

4.5. Novel therapies for dealing with trauma 'wounds':

- Somatic therapies for healing trauma wounds
  - **Resource**: Healing Trauma by Peter Levine: Resolving the Trapped Fight/Flight/Freeze Response, https://youtu.be/twMSB8yuZbw
- Eye movement desensitization and re-imagination (EMDR)
  - **Resource**: What is EMDR Therapy? https://youtu.be/1IPsBPH2M1U

4.6. Implement Indigenous-led healing modalities, and recognition that settler colonialist systems are at the root of the disproportionate social, health and well-being challenges experienced by Indigenous Peoples on and off Reserves.

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[2] https://www.semanticscholar.org/paper/Post-traumatic-stress-disorder-and-substance-use-in-Luteijn-VanDerNagel/62bfb335deb3fc4caa7e30251b2fff546913f2fd

[3] https://www.semanticscholar.org/paper/Examining-Barriers-as-Risk-Factors-for-Relapse%3A-A-McQuaid-Jesseman/eff492ffd3d8debf2143d5feb9edc59535d432de

[4] https://www.semanticscholar.org/paper/Essential-Elements-That-Contribute-to-the-Recovery-Jaiswal-Carmichael/9c064f3eae44fea2b1902eb0259fc8bc49045c88

- **Resources**:
  - Blending Aboriginal and Western Healing Methods to Treat Intergenerational trauma with Substance Use Disorder in Aboriginal Peoples who Live in Northeastern Ontario - https://harmreductionjournal.biomedcentral.com/track/pdf/10.1186/s12954-015-0046-1.pdf
  - Engaging Indigenous People who use Substances - https://rnao.ca/bpg/courses/engaging-indigenous-people-who-use-substances
  - Indigenous Peoples and COVID-19 - https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/indigenous-peoples-covid-19-report.html

#5. Life Skills Training, Employment and Meaningful Activity

Staving off drug dealing, theft, as well as lowering the risk of involvement in trafficking or survival sex work requires a constellation of innovative interventions.

Recommendations:

5.1. Low-threshold employment opportunities for people who use substances (learning, cognitive and physical disabilities can negatively impact employability).

5.2. ICH's Community Support Program (CSP) - hiring of people with lived or living experience to act as peer supports – formal paid employment, engagement, and participation in decision-making activities like program planning and problem-solving.

5.3. Social Entrepreneurship.

5.4. Life skills training, mentoring, peer programming.

5.5. Meaningful Activity – creative and therapeutic modalities.

#6. Housing and Income Supports

Addressing an unmet need in our community, the ICH provides a supervised environment for people who use substances and/or may be experiencing homelessness who may otherwise congregate in encampments, without the safety measures of Consumption and Treatment Services, crisis and overdose intervention, and security patrols of the area in which these people now congregate around the ICH.

Recommendations:

6.1. For emergency shelters, more private rooms are needed: capacity for physical isolating (infectious disease control), privacy for couples, ability to lock away belongings to reduce theft.

6.2. Sustainable support for the ICH to continue services that are low-barrier, accessible and trauma-informed that serve a pre-existing community with cognitive, behavioural, mental health and/or substance use challenges (Marshall et al., 2021, recommendation #2, #4, & #8).

6.3. Also needed is a second stage housing option for people in active substance use that allows for communal living with the privacy of personal space as well as the ability to access on-site wrap-around supports based on the individual goals of a person's healing journey.

6.4. Overdose prevention needs to be prioritized in the development and delivery of care programming.

6.5. Income supports that are equitable: Participants strongly stated the need for affordable, safe, healthy, *decent* housing for lower income persons and families. This situation is inequitable for people on social assistance and/or a fixed income whereby people who are unable to work for whatever reason, are treated differently (Marshall et al., 2021, recommendation #9).

Populations Requiring Special Consideration

The following populations have unique needs, and further consultation with them is required to better understand how to serve them.

a) Outreach to women under 30 who use substances who are under-represented in the needs assessment, and may be subject to trauma, violence, involvement in trafficking or survival sex work
b) People who self-identify as Indigenous are over-represented in the needs assessment, are subject to a history of intergenerational trauma and poverty, are repeatedly exposed to potentially morally injurious events due to systemic racism and lateral violence, are often forbidden from practicing their own spiritual healing rituals or cannot access culturally appropriate and safe programming.
c) Veterans, who may have a history of trauma, PTSD, exposure to potentially morally injurious events, and concerns over help-seeking as potentially stigmatizing within their professional culture.
d) People who are physically disabled and/or suffering from chronic pain: Mental health and substance use challenges will exacerbate their chronic conditions, creating negative feedback loops that may keep them from participating in the formal labour force indefinitely, but they still wish to be contributing members of society. Chronic pain may limit the employment they can engage in.

Conclusion

The ICH needs assessment involved consultations with 32 stakeholders who have used/use crystal meth and/or opioids. Challenges to social, health, criminal justice and education systems have been identified, many beyond the scope of the ICH. Five major assumptions on how to better the lives of these people are articulated, providing a 'spirit of moving forward' that acknowledges health and social justice for all; that stigma and discrimination exists in our institutions that has caused harm; that the people served at the Hub have very complex conditions referred to as tri-diagnosis; that people who use substances have a specialized community of their own but long for a 'second chance' to reintegrate into employment and reconnect with their families; and that an integrated care model could be the key to their healing. Four populations worthy of special consideration and further inquiry are identified: women under thirty, Indigenous people, Veterans, and people with chronic pain and/or physical disabilities. Six broad areas of recommendations on how we can do better are outlined: anti-stigma training and awareness; harm reduction, decriminalization, and in-patient rehabilitation; prevention of moral injury; healing centred engagement and wellness services and programming; life skills training, employment, and meaningful activities; and housing and income supports. We hope the recommendations contained in this synopsis inform collaborative problem solving and program design across sectors to better our current provision of supports to people who use substances by addressing systemic challenges. The staff and management at the Integrated Care Hub cannot accomplish this alone. We hope to achieve a commitment from all health care and service agencies within the KFL & A Region – housing, policing, hospital and community services – to work together to address these recommendations.