Building Partnerships for Health

A Strategic Planning Framework for Injection Drug Use in Saskatoon

A report produced by Saskatoon Health Region – Public Health Services

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Building Partnerships for Health: A strategic planning framework for injection drug use in
Saskatoon
Department of Disease Control
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Commentary

Injection Drug Users (IDUs), their partners and children have increasingly accounted for more new HIV cases in the Saskatoon Health Region (SHR) since 2003. In 2004, 40% of all new HIV positive individuals reported injection drug use as their major risk factor making this the largest risk factor group\(^1\). This number has increased to 60% in 2006. Disproportionate to the national average, the majority of new HIV cases in the SHR self identify as Aboriginal and female IDUs are increasingly represented among these cases.

Clearly, significant challenges remain ahead. We need to drastically reduce the spread of HIV by adopting more effective prevention programs, providing access to treatment and care for all who require it, and improving the overall control of the epidemic by examining closely how the array of services needed by these special populations are currently made available.

In an effort to address the complex challenges surrounding injection drug use in Saskatoon more systematically, the Medical Health Officer has called together an Injection Drug Use Task Force. This Task Force is a collaborative, intersectoral approach to planning for the needs of injection drug users along a continuum of needs and services. The overall goal of this task force is to identify what resources are currently available to injection drug users in Saskatoon and to map out care pathways for this client group. Findings of the Task Force have been shared with stakeholders in two general meetings and all the information now presented in the report, “Building Partnerships for Health – A Strategic Planning Framework for Injection Drug Use in Saskatoon”.

It is hoped that the partnership and integrated model of care discussed and presented in this report will be used to standardize services offered and to inform and guide stakeholders in the health region in establishing priorities to meet the needs of people who use injection drugs.

Dr. Johnmark Opondo MB.Ch.B., MPH
Deputy Medical Health Officer

\(^1\) Report of the Medical Health Officer, Saskatoon Health Region, Public Health Services. April 2006. Investigation of an HIV cluster among IDUs in Saskatoon, Saskatchewan using the social network approach.
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MHAS: Mental Health and Addiction Services
PHS: Public Health Services
SHR: Saskatoon Health Region
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<td>CAAN</td>
<td>Canadian Aboriginal AIDS Network</td>
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<td>CAMH</td>
<td>Centre for Addiction and Mental Health</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CDSA</td>
<td>Controlled Drugs and Substances Act</td>
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<td>CUISR</td>
<td>Community University Institute for Social Research</td>
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<td>HCV</td>
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<td>HEP</td>
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<td>IDUs</td>
<td>Injection Drug Users</td>
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<td>MAR</td>
<td>Methadone Assisted Recovery</td>
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<td>MHO</td>
<td>Medical Health Officer</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>PHS</td>
<td>Public Health Services</td>
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<td>PLWA</td>
<td>Persons Living with HIV/AIDS</td>
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<td>SCR</td>
<td>Saskatchewan Community Resources</td>
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<td>SHR</td>
<td>Saskatoon Health Region</td>
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<td>Saskatoon Integrated Drug Unit</td>
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<td>UN</td>
<td>United Nations</td>
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Executive Summary

This strategic planning document was developed under the leadership of Public Health Services--Saskatoon Health Region. The report is intended to serve as a foundation for building partnership around the Saskatoon Injection Drug Use (IDU) Strategy. The report draws from the experience of stakeholders, evidence-informed best practices and strategic planning to create a foundation for partnership between service providers, community-based organizations, communities and individuals.

A number of national, provincial and regional responses have emerged from growing concern related to the health risks associated with IDU. A National Framework for Action calls for strategic responses to substance use and related problems across the country. In 2005, Saskatchewan’s provincial government responded to the issue through Project Hope with a goal to strengthen substance abuse prevention and treatment services. In the same year, the Saskatoon Tribal Council Urban First Nations Services led the development of the Saskatoon Youth Addictions Strategy based on a four pillar approach adapted from Vancouver’s Framework for Action.

Public Health Services--Saskatoon Health Region has responded with investigations into recent outbreaks and facilitating the development of this strategic planning document. This document is intended to stimulate dialogue and planning among stakeholders as they partner around addressing IDU concerns from their specific institutional or community perspective. More specifically, the strategic planning framework proposed helps identify and manage the needs of people who use injection drugs in the community in a more coordinated fashion based on the development of a continuum of care.

Partnering around IDU

The Saskatoon IDU Strategy aims to foster collaboration between stakeholders from various disciplines, organizations and communities under a shared vision to improve health and social outcomes for both IDUs and the greater community of Saskatoon. Building partnership around IDU can facilitate collaborative and comprehensive responses, strengthen services and programs, and enhance best practices. This strategic planning framework proposes the establishment of a partnership organized by a four-pillar framework that encompasses prevention, harm reduction, treatment and recovery, and enforcement dimensions of IDU.

The key to effective partnership around IDU is effective communication between various services and service providers, community-based organizations, and communities.

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2 Project Hope is a provincial action plan for substance abuse. Details are available on the website (http://www.health.gov.sk.ca/fs_090205_projecthope.htm).
**Goals & Guiding Principles**
The strategy focuses on leadership and coordination, awareness, education and training, and research and evaluation. The target populations for this strategy include IDUs, communities, and children, youth and families. The strategies and recommendations emerging from this planning document are guided by the principles of acceptance, access, balance, collaboration, determinants of health, evidence-based practice, participation and partnership.

**Partnering for Improved Health for Aboriginal People**
Integral to this strategy is an explicit recognition of the disproportionate burden of IDU experienced by Aboriginal people. This greater burden of IDU results from the complex interaction of contextual factors (e.g. higher rates of poverty and unemployment; systematic discrimination and racism; and the multigenerational effects of residential schools). These factors contribute to higher rates of suicide, violence and substance abuse than may be experienced in other communities in Canada. Compounding this disproportionate burden of IDU, the incidence of HIV infections is growing faster among Aboriginal people than any other group in Canada. Given Aboriginal people’s high risk for exposure to HIV, HCV and other blood-borne pathogens, it is important that partnership around IDU both acknowledge and respect the unique needs of this population and ensure active participation of Aboriginal stakeholders.

**Partnering to Develop an IDU Continuum of Care**
Partnership around IDU contributes to improved communication and collaboration between service providers. These improvements promote greater coordination of services and can improve access to services for a population that may experience marginalization, stigma or difficulty accessing traditional health and social services. The development of an IDU continuum of care standardizes the ways in which clients access, move through, and communicate with service providers with greater consistency and greater potential for improved health and well-being among communities and IDUs. The IDU continuum of care is hoped to transform the delivery of care for IDUs, promote health and well being in our community, and create a seamless continuum of services to ensure IDUs and their families receive comprehensive, timely services.

**A Four Pillar Framework**
Several cities across Canada have adopted a four pillar approach to organize and develop strategic responses to IDU. The recommendations of the Saskatoon IDU Strategy are also strategically organized using the four pillars of Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery. These pillars provide a structure in which working groups can organize around to consider different series of recommendations. Integration and planning across these four pillars is a critical foundation for successful partnership.
**Recommendations & Suggested Strategies**

The organization of the report into four pillars is reflected by the series of recommendations emerging from consultation with stakeholders and a comprehensive review of the literature and evidence-informed best practices related to IDU. Each recommendation provides a number of short and long-term strategies informed by stakeholder suggestions, current best practices and research. The first steps towards partnering around the Saskatoon IDU Strategy are guided by foundational and pillar-specific recommendations. A summary of these recommendations is provided in Table E-1 below.

| Integration & Planning Across Four Pillars | F.1  | Improve coordination and communication between agencies and nominate lead for facilitating overall coordination of the strategy. |
|                                          | F.2  | Collaborate across each of the four pillars to ensure a comprehensive and individualized approach that addresses a broad range of client and community needs. |
|                                          | F.3  | Engage clients in the planning, development and implementation of all programs aimed at IDU. |
|                                          | F.4  | Engage youth in the planning, development and implementation of all programs aimed at children and youth. |
|                                          | F.5  | Incorporate culturally relevant dimensions into strategic planning and programming aimed at improving the health and well-being of Aboriginal communities, including spiritual and traditional practices. |
|                                          | F.6  | Develop a collaborative program of action-research for the Saskatoon IDU Strategy that facilitates the engagement of stakeholders in the process of developing best practices, monitoring and evaluating initiatives, and establishing effective working groups under each pillar. |

| Health Promotion & Primary Prevention    | P.1  | Strengthen programs which address the major social determinants leading to injection drug use. |
|                                          | P.2  | Develop social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and injection drug users. |
|                                          | P.3  | Develop school-based prevention program from kindergarten to grade 12. |
|                                          | P.4  | Enhance skill and esteem building programs for youth and families. |
|                                          | P.5  | Enhance positive community-based prevention programs for at-risk youth. |

<p>| Harm Reduction                          | H.1  | Develop clear definition of harm reduction and incorporate philosophy into each service provider’s policy of practice. |
|                                          | H.2  | Develop an intensive education program about harm reduction that is tailored for IDUs, the community and service providers. |
|                                          | H.3  | Expand outreach services through existing organizations. |
|                                          | H.4  | Advocate for increased community-based access to harm reduction services. |
|                                          | H.5  | Continue Needle Safe Saskatoon partnership. |</p>
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<td><strong>H.6</strong></td>
<td>Expand harm reduction strategies beyond needle exchange to include the provision of a full range of injection drug equipment.</td>
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<td><strong>H.7</strong></td>
<td>Pending successful evaluation of <em>Insite</em> (Canada’s first safe injection site) and federal approval for expansion of similar programs, consider a safe injection site for Saskatoon.</td>
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<td><strong>Enforcement</strong></td>
<td><strong>E.1</strong></td>
<td>Adopt a holistic approach that recognizes the social determinants underlying addictions and drug-related crime.</td>
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<td><strong>E.2</strong></td>
<td>Advocate for drug addiction to be re-positioned as a health issue, with the creation of a separate drug court.</td>
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<td><strong>E.3</strong></td>
<td>Advocate for the use of diversionary programs and alternative sentencing for youth charged with a drug-related offense.</td>
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<td><strong>E.4</strong></td>
<td>Consider advocating for laws that decriminalize the possession of drugs for personal use.</td>
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<td><strong>E.5</strong></td>
<td>Advocate for enforcement efforts in policing and through the criminal justice system to be focused on supply reduction.</td>
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<td><strong>Treatment &amp; Recovery</strong></td>
<td><strong>T.1</strong></td>
<td>Understand and reflect in treatment the principle that injection drug use is first and foremost a health issue with social consequences.</td>
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<td><strong>T.2</strong></td>
<td>Develop a centralized, 24-hour manned depot to provide treatment options and referrals, drug-related information and assistance.</td>
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<td><strong>T.3</strong></td>
<td>Collaborate to improve information sharing and coordination of treatment services for injection drug users.</td>
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<td><strong>T.4</strong></td>
<td>Ensure that progression from detoxification to treatment services is timely and responsive to individual client needs.</td>
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<td><strong>T.5</strong></td>
<td>Advocate for treatment and detoxification services that are tailored for injection drug use.</td>
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<td></td>
<td><strong>T.6</strong></td>
<td>Develop youth-specific treatment centres and program family involvement, support and education into the treatment and recovery process.</td>
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<td><strong>T.7</strong></td>
<td>Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.</td>
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<td><strong>T.8</strong></td>
<td>Work in partnership with clients and their circle of care in a coordinated effort to plan and manage the recover process.</td>
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<td><strong>T.9</strong></td>
<td>Recognize that cultural and spiritual experiences are integral to the recovery process for IDU clients.</td>
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<td></td>
<td><strong>T.10</strong></td>
<td>Address barriers to the access and availability of treatment and recovery services for IDU clients.</td>
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<td></td>
<td><strong>T.11</strong></td>
<td>Ensure a flexible and supportive client-centered plan for follow-up in the community.</td>
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Part 1: Introduction & Overview

We envision a collaborative, participative partnership around IDU that:

- Provides all relevant and interested stakeholders with a voice and role.
- Promotes awareness of the risks of IDU through active community engagement.
- Advocates for reducing stigma and discrimination against IDU.
- Respects the rights and needs of everyone for timely, consistent, and supportive access to judgment-free services.
- Acknowledges the importance of partnering for improving health for Aboriginal people.
- Strives to create greater continuity of care through enhanced collaboration among service providers and community-based organizations engaged in prevention, harm reduction, enforcement or treatment and recovery for IDU.

This strategic planning document was developed by Public Health Services (PHS)--Saskatoon Health Region (SHR). The report offers a foundation for building partnership around the Saskatoon Injection Drug Use (IDU) Strategy, drawing from the experience of stakeholders, evidence-informed best practices and strategic planning to create a foundation for partnership between service providers, community-based organizations, communities and individuals.

A number of national, provincial and regional responses have emerged from growing concern related to the health risks associated with IDU. A National Framework for Action calls for strategic responses to substance use and related problems across the country (1). In 2005, Saskatchewan’s provincial government responded to the issue through Project Hope with a goal to strengthen substance abuse prevention and treatment services. In the same year, the Saskatoon Tribal Council Urban First Nations Services led the development of the Saskatoon Youth Addictions Strategy based on a four pillar approach adapted from Vancouver’s Framework for Action. Public Health Services has responded with investigations into recent increases in the rates of both Human Immunodeficiency Virus (HIV) and Hepatitis C Virus (HCV) and facilitating the development of this strategic planning document.
This document is intended to stimulate dialogue and planning among stakeholders as they partner around addressing challenges related to IDU. Through the construction of partnership between service providers, community organizations, communities and IDUs, we can facilitate collaboration, improve communication, strengthen services and programs, and enhance best practices. A four pillar framework for this partnership incorporates prevention, harm reduction, treatment and enforcement dimensions of IDU under an integrated strategy to reduce the risks associated with IDU in the SHR.

Guiding Principles
The strategy’s primary goals focus on: leadership and coordination; awareness, education and training; and research and evaluation. The target populations for this strategy include IDUs, communities, and children, youth and families. As the strategy evolved from consultation into a strategic plan, eight principles guided the development of recommendations and suggested actions. These principles are described in Table 1.1 below.

Table 1.1: Guiding Principles

<table>
<thead>
<tr>
<th>Acceptance</th>
<th>The strategy is respectful, aims to reduce stigma among communities and service providers, and accepts and welcomes all individuals wherever they are with their use of injection drugs.</th>
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<tr>
<td>Access</td>
<td>The strategy is balanced, promoting equitable allocation of resources across four pillars.</td>
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<tr>
<td>Balance</td>
<td>The strategy is balanced, promoting equitable allocation of resources across four pillars.</td>
</tr>
<tr>
<td>Coordination &amp; Collaboration</td>
<td>The strategy develops and implements actions in a coordinated manner with a client-focus across four pillars.</td>
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<td>Determinants of Health</td>
<td>The strategy is holistic and multi-dimensional, engaging grassroots program planning directed at foundational determinants of health(^1).</td>
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<td>Evidence-based Practice</td>
<td>The strategy is scientific, community-based and incorporates user experiences into the establishment of best practices strategies to guide service planning, implementation and evaluation.</td>
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<td>Participation</td>
<td>The strategy incorporates significant and meaningful involvement of current and recovering IDUs in its planning, development, delivery and evaluation.</td>
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\(^1\)Foundational determinants of health include: Income and social status; Social support networks; Education and literacy; Employment/working conditions; Social environments; Physical environments; Personal health practices and coping skills; Healthy child development; Biology and genetic endowment; Health services; Gender; Culture (http://www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html#key_determinants).
### Developing a Strategy for Injection Drug Use

In response to an observed increase in blood-borne pathogens (HIV and HCV) among injection drug users in Saskatoon, the Chief Medical Health Officer called together an IDU Task Force within Public Health Services in the Saskatoon Health Region in 2002. The mandate of the IDU Task Force was to initiate a collaborative, intersectoral approach to planning for the needs of injection drug users (IDUs) along a continuum of care.

In 2004 the PHS IDU Task Force, under the leadership of the Deputy Medical Health Officer (MHO), completed an environmental scan to describe the context of IDU in Saskatoon. This included a survey with service providers to explore service availability, program gaps, and barriers to access. The survey also included consultation around the concept of a continuum of care. The report (2) served as a foundational background for the development of this strategic plan.

The IDU Task Force also brought key partners and stakeholders together at Stakeholder Meetings in October of 2005 and October of 2006. These meetings offered opportunities to consult with key service providers, organizations and community members to develop recommendations for the Saskatoon IDU Strategy. This report extends the consultation process to incorporate research, literature, and evidence-informed best practice into stakeholders’ recommendations.

**Who was involved in developing the strategy?**

In partnership with a number of key stakeholders, PHS has taken a preliminary facilitating role in the development of this strategy. At the end of 2006, the PHS IDU Task Force was formed to facilitate the completion of this document and move forward to the next level—forming an IDU Steering Committee and the Four Pillar Working Groups. These two bodies will expand to include all relevant stakeholders as the Four Pillar Working Groups (sometimes referred to as simply ‘working groups’) consider the recommendations in this strategy and move forward into action.

The key actors in the Saskatoon IDU Strategy (described in more detail below) include stakeholders, the PHS IDU Task Force, the IDU Steering Committee, and the four pillar working groups. As the strategy moves forward in partnership, the key actors should expand to include stakeholder representation from First Nations and Métis communities, youth, community members and other community organizations.
Stakeholders
Stakeholders are service providers, community organizations, advocacy groups and active community members who identify prevention, harm reduction, treatment or enforcement issues related to IDU among any of their priorities, objectives or mission statements. A number of diverse stakeholders were invited to participate in the October 2005 and 2006 meetings.

PHS IDU Task Force
The PHS IDU Task Force is made up of the Medical Health Officer, the Manager of the Healthy Lifestyles Department, the Supervisor of the Street Health Program, an Epidemiologist, and a Public Health Nurse Clinician (Sexual Health). This task force reviewed the context around IDU, increasing rates of HIV and HCV and made preliminary decisions about the role PHS could take on in the first steps towards developing an integrated strategy for IDU.

IDU Steering Committee (to be established)
The IDU Steering Committee will consist of a representative from each of the working groups (Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery) and members of the PHS IDU Task Force. Committee membership and functions will be finalized by this group as stakeholders move forward into action.

Four Pillar Working Groups (to be expanded)
The working groups are open, inclusive, dynamic and participatory. Working groups currently include representatives who identified with one of the pillar strategies during stakeholder meetings in 2005 and 2006. Membership in these working groups will expand as each pillar considers the foundational and pillar specific recommendations. As membership in the working groups expand, emphasis should be placed on the importance of active participation of Aboriginal stakeholders, communities, youth and IDUs.
How to Use this Report
This report is intended to serve as a resource and tool for strategic planning. It is organized by sections that are either foundational or specific to one of the four pillars (Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery). Parts 1-3 are foundational to the strategic planning across the four pillars. These sections highlight the context of IDU in the SHR, describe how to create successful partnership, and offer suggestions for how to address the foundational goals of the proposed strategy. Parts 4-7 focus on research and literature specific to each of the four pillars. For these sections of the report, stakeholders may choose to focus on the pillars most relevant to their work as a starting point.

A Four Pillar Framework
The Saskatoon IDU Strategy is organized by four pillars (See Table 1.2) and coordinated through foundational recommendations for integration and planning across these pillars. Preliminary working groups have already been established under each of these pillars, but will continue to grow and expand in mentorship as the Saskatoon IDU Strategy evolves into an effective, comprehensive partnership.

Table 1.2: Four Organizational Pillars

<table>
<thead>
<tr>
<th>Health Promotion &amp; Primary Prevention</th>
<th>Includes strategies that promote health and strive to prevent IDU. In addition to education and raising awareness, prevention efforts also include the strengthening of social, economic and health parameters, including access to stable housing, education, employment and health care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm Reduction</td>
<td>Includes strategies that reduce the harm for people who use injection drugs and that contribute to reducing drug-related harm rather than drug use.</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Includes strategies that address issues related to illegal drugs and their control such as the need for peace, public order, and safety in our homes, local neighborhoods and the entire city.</td>
</tr>
<tr>
<td>Treatment &amp; Recovery</td>
<td>Includes strategies that improve the physical, emotional and psychological health and wellbeing of current and former IDUs through various psychosocial, psychopharmacological, and spiritual or cultural healing methods.</td>
</tr>
</tbody>
</table>
Recommendations

At the October 2005 Stakeholders' Meeting, representatives from government, community, non-government organizations working in or around health, social and enforcement issues identified priority actions that were needed to address injection drug use in our community. The actions were generated through a brainstorming activity under the four pillar framework. Together, this review and stakeholder consultations led to the development of the recommendations presented here. The recommendations, short and long-term strategies and expected outcomes each reflect the identified concerns and priorities of stakeholders in addressing IDU service issues and grounds these concerns and priorities in research and demonstrated best practices².

The Saskatoon IDU Strategy recommendations are detailed in Parts 3-7 of this document. Each of these sections includes an introduction and discussion of current, evidence-informed best practices based on research, literature and stakeholder consultation. This background information is followed by a series of either foundational or specific recommendations which are also grounded in the literature and stakeholder consultation. Recommendations specific to any of the four pillars may be complementary to recommendations or work in other pillars (Cross-referenced in Table 1.3). Working groups may decide to collaborate on these recommendations as they feel appropriate.

The recommendations presented in this document are intended as starting points for working groups as they move forward into action. Working groups are encouraged to consider both the foundational recommendations and those specific to their pillar(s). Each recommendation includes:

- A series of suggested short-term strategies to address the recommendation. These strategies can be implemented with little or no additional resources.
- A series of suggested long-term strategies that would require additional financial or human resources and greater investment in planning.
- Expected outcomes for each recommendation that are linked to suggested strategies.
- Suggestions of potential lead agencies and partner agencies.

² Best Practices are a series, set or grouping of practices that are demonstrated through both research and collective experience as effective, beneficial and appropriate. Best practices do not necessarily reflect the ‘only’ approach, nor are they intended to create hierarchy among strategies or approaches. Instead, they summarize what we currently know through experience, demonstrated effectiveness and evaluation, and research to be the best practice that we can offer in a particular context.
Table 1.3: Summary of Recommendations by Pillar

<p>| Integration &amp; Planning Across Four Pillars | F.1  | Improve coordination and communication between agencies and nominate lead for facilitating overall coordination of the strategy. |
|                                          | F.2  | Collaborate across each of the four pillars to ensure a comprehensive and individualized approach that addresses a broad range of client and community needs. |
|                                          | F.3  | Engage clients in the planning, development and implementation of all programs aimed at IDU. |
|                                          | F.4  | Engage youth in the planning, development and implementation of all programs aimed at children and youth. |
|                                          | F.5  | Incorporate culturally relevant dimensions into strategic planning and programming aimed at improving the health and well-being of Aboriginal communities, including spiritual and traditional practices. |
|                                          | F.6  | Develop a collaborative program of action-research for the Saskatoon IDU Strategy that facilitates the engagement of stakeholders in the process of developing best practices, monitoring and evaluating initiatives, and establishing effective working groups under each pillar. |
| Health Promotion &amp; Primary Prevention     | P.1  | Strengthen programs which address the major social determinants leading to injection drug use. |
|                                          | P.2  | Develop social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and of injection drug users. |
|                                          | P.3  | Develop school-based prevention program from kindergarten to grade 12. |
|                                          | P.4  | Enhance skill and esteem building programs for youth and families. |
|                                          | P.5  | Enhance positive community-based prevention programs for at-risk youth. |
| Harm Reduction                           | H.1  | Develop clear definition of harm reduction and incorporate philosophy into each service provider’s policy of practice. |
|                                          | H.2  | Develop an intensive education program about harm reduction that is tailored for IDUs, the community and service providers. |
|                                          | H.3  | Expand outreach services through existing organizations. |
|                                          | H.4  | Advocate for increased community-based access to harm reduction services. |
|                                          | H.5  | Continue Needle Safe Saskatoon partnership. |
|                                          | H.6  | Continue and expand harm reduction strategies beyond needle exchange to include the provision of a full range of injection drug equipment. |
|                                          | H.7  | Pending successful evaluation of Insite (Canada’s first safe injection site) and federal approval for expansion of similar programs, consider a safe injection site for Saskatoon. |
| Enforcement                              | E.1  | Adopt a holistic approach that recognizes the social determinants underlying addictions and drug-related crime. |
|                                          | E.2  | Advocate for drug addiction to be re-positioned as a health issue, with the creation of a separate drug court. |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>E.3</strong></td>
<td>Advocate for the use of diversionary programs and alternative sentencing for youth charged with a drug-related offense.</td>
</tr>
<tr>
<td><strong>E.4</strong></td>
<td>Consider advocating for laws that decriminalize the possession of drugs for personal use.</td>
</tr>
<tr>
<td><strong>E.5</strong></td>
<td>Advocate for enforcement efforts in policing and through the criminal justice system to be focused on supply reduction.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Treatment &amp; Recovery</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>T.1</strong></td>
<td>Understand and reflect in treatment the principle that injection drug use is first and foremost a health issue with social consequences.</td>
</tr>
<tr>
<td><strong>T.2</strong></td>
<td>Develop a centralized, 24-hour manned depot to provide treatment options and referrals, drug-related information and assistance.</td>
</tr>
<tr>
<td><strong>T.3</strong></td>
<td>Collaborate to improve information sharing and coordination of treatment services for injection drug users.</td>
</tr>
<tr>
<td><strong>T.4</strong></td>
<td>Ensure that progression from detoxification to treatment services is timely and responsive to individual client needs.</td>
</tr>
<tr>
<td><strong>T.5</strong></td>
<td>Advocate for treatment and detoxification services that are tailored for injection drug use.</td>
</tr>
<tr>
<td><strong>T.6</strong></td>
<td>Develop youth-specific treatment centres and program family involvement, support and education into the treatment and recovery process.</td>
</tr>
<tr>
<td><strong>T.7</strong></td>
<td>Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.</td>
</tr>
<tr>
<td><strong>T.8</strong></td>
<td>Work in partnership with clients and their circle of care in a coordinated effort to plan and manage the recover process.</td>
</tr>
<tr>
<td><strong>T.9</strong></td>
<td>Recognize that cultural and spiritual experiences are integral to the recovery process for IDU clients.</td>
</tr>
<tr>
<td><strong>T.10</strong></td>
<td>Address barriers to the access and availability of treatment and recovery services for IDU clients.</td>
</tr>
<tr>
<td><strong>T.11</strong></td>
<td>Ensure a flexible and supportive client-centered plan for follow-up in the community.</td>
</tr>
</tbody>
</table>
Moving Forward

Moving these recommendations into action requires the time, energy and resources of stakeholders in each of the four pillars. Making sure we build this strategy collaboratively, with active participation of all stakeholders, means that we need to invest in process, building the team from the ground-up.

A Toolbox for Action

So now we have all of these recommendations, four pillars, and some ideas about how to build a partnership: Now what?

There are some things that each working group can do in the first few steps towards action to ensure that the groups:

- Know who the stakeholders in the group are
- Determine what skills, resources and experiences each stakeholder can offer
- Explore what contexts are important to each stakeholder
- Discover what priorities exist (and why they exist) for each stakeholder
- Discuss what direction each stakeholder would like to see the IDU Strategy take on
- Negotiate a direction for action that is agreeable to all stakeholders

These tools will help working groups take the first steps towards action (provided in Appendix A):

- Rapid Assessment Tool for Stakeholders
- First Workshop Guide
- Case Studies
- Mapping Exercise: Continuum of care
- Selected Resources: Links to other tools and strategies
References


Part 2: Profile of IDU in Saskatoon

This section provides some quick facts about IDU to provide stakeholders with a brief overview of IDU in Saskatoon. Data presented below were taken from the reports *IDU in Saskatoon: Developing a continuum of care* (1) and the April 2006 Report of the Medical Health Officer exploring a cluster of HIV infection among IDUs in Saskatoon (2).

Figure 2.1 below summarizes the age and sex of clients accessing services from the *Street Works* van between December 2005 and December 2006. The majority of clients were between 20 and 39 years of age. Of those clients under 39, a greater proportion was female and a greater proportion of males were represented among those clients 40 years of age and over\(^1\).

\[n=787\]

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\(^1\) It is important to note that these data represent clients accessing the *Street Works* van only and do not necessarily represent all individuals who use injection drugs in the SHR.
Figure 2.2 displays the drugs identified by IDU clients interviewed during the HIV cluster investigation (2) as their injection drugs of choice. Most participants identified more than one injection drug. Cocaine and morphine were most commonly identified as preferred drugs (80% and 74% of clients respectively). The second most commonly identified drugs were Talwin or Ritalin and Dilaudid (55% of clients).

**Understanding IDU Practices**

IDUs interviewed during the HIV cluster investigation were also asked to comment on the circumstances surrounding their first experience with injecting. Participants were most commonly with friends or family during the first time they used injection drugs. Although the majority of participants were over 18 when they first used injection drugs, initiation of injection drug use was as young as 12 for both males and females (Table 2.1).

Of IDU clients interviewed in the HIV cluster investigation, a large proportion shared gear at least once and just under half shared gear in the last six months despite being aware of the risks of sharing (Figure 2.3). Further to this, the majority of IDUs report that they inject with other people (Figure 2.4).

The initiation into injection drug use through friends and family members, the tendency to share gear and inject with other people highlights the need for improved prevention and harm reduction efforts within networks of IDUs and among IDUs who access services such as the Street Works van.
### Table 2.1: IDU Initiation in the SHR

<table>
<thead>
<tr>
<th>Of the IDUs who participated in the HIV Cluster Investigation…</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>On average, what age do people first use injection drugs?</td>
<td>22 years (Range 12-36 years)</td>
<td>19 years (Range 12-48 years)</td>
</tr>
</tbody>
</table>
| Who are people with when they first use injection drugs?    | • 30% first use with friends  
• 27% first use with a family member  
• 20% first use with a sex partner  
• People are rarely with a stranger when they first use |
| Where are people when they first use injection drugs?       | • 33% first use at a friend’s place  
• 20% first use at their own home  
• 18% first use at a family member’s home  
• 7% first use at a shooting gallery  
• People rarely first use at bars, restaurants, streets or public washrooms |

#### Figure 2.3: Sharing of Needles or Injection Gear among IDUs in the SHR, 2006

- **n=65**

[Graph showing number of clients ever shared gear, recently shared gear, and aware of risks of sharing gear for males and females.]
Accessing Services
Considering the risks of IDU, particularly given its social nature in the SHR, it is important to consider what prevention, harm reduction, treatment and enforcement services are accessed by IDUs.

Prevention & Harm Reduction
Figure 2.5 below shows that the majority of IDUs interviewed in the HIV cluster investigation accessed clean needles from both drug stores and the Health Works van. Commonly identified barriers to accessing clean needles are displayed in Figure 2.6, which draws attention to the need for comprehensive hours of needle exchange services. Since the HIV cluster investigation, needle exchange offered through PHS has expanded its hours to include daytime outreach as well as Saturday services. PHS also offers sexual health education in schools and community organizations, condom distribution, and STI testing, treatment and contract tracing. Table 2.2 summarizes service gaps, barriers and needs related to IDU in the SHR. These challenges were identified through consultation with representatives attending the October 2005 stakeholder meeting.
Figure 2.5: Where do IDUs get Clean Needles From? SHR, 2006

Figure 2.6: IDU-Identified Barriers to Accessing Clean Needles in the SHR
Table 2.2: Stakeholder-identified Challenges relative to IDU in Saskatoon

<table>
<thead>
<tr>
<th>Service Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Short-term detoxification and long-term rehabilitation with family supports</td>
</tr>
<tr>
<td>■ Safe housing facilities outside the city</td>
</tr>
<tr>
<td>■ A safe injection site</td>
</tr>
<tr>
<td>■ A satellite/drop-in infectious diseases clinic</td>
</tr>
<tr>
<td>■ Programs for restorative justice</td>
</tr>
<tr>
<td>■ Improved Transportation services</td>
</tr>
<tr>
<td>■ A site that offers integrated services</td>
</tr>
<tr>
<td>■ IDU paraphernalia exchange (syringes, spoons, filters, cookers)</td>
</tr>
<tr>
<td>■ More physicians certified to prescribe methadone</td>
</tr>
<tr>
<td>■ Broader prevention programming for children and youth</td>
</tr>
<tr>
<td>■ Services for clients with multiple health issues</td>
</tr>
<tr>
<td>■ Programs/services for children and youth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Lack of coordination and communication among service providers</td>
</tr>
<tr>
<td>■ Lack of physical accessibility to pharmacies and treatment centres</td>
</tr>
<tr>
<td>■ Limited outreach services, sites and hours of operation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to Continuity of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Limited staff, space, training and resources are available</td>
</tr>
<tr>
<td>■ Poor or little information sharing occurs between agencies</td>
</tr>
<tr>
<td>■ Services are fragmented</td>
</tr>
<tr>
<td>■ Follow-up on clients once referred is difficult</td>
</tr>
</tbody>
</table>

_Treatment_
In response to _Project Hope_², Saskatchewan Health saw a 60% budget increase for substance abuse prevention and treatment funding for the 2005-2006 fiscal year. This increase in funding translated into the opening of six interim youth stabilization beds in both Saskatoon and Prince Albert in 2006 with plans to open permanent facilities of 12 and 15 beds respectively in 2007 (3).

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² _Project Hope_ is a three-year provincial plan to prevent substance abuse and lessen its harms to individuals and families that was announced by Premier Lorne Calvert in 2005.
Figure 2.7 shows the number of people receiving alcohol or drug services in the SHR over a one year period. Across all age groups, a larger proportion of males accessed alcohol and drug services during this time. The majority of individuals accessing services were 20 and older, however a substantial proportion (11%) of all services provided were for youth under 19 years of age (4).

The Methadone Assisted Recovery Program (MAR) is a partnership between physicians working under the guidelines of the Royal College of Physicians and Surgeons and Community Addictions Services for the SHR. MAR incorporates harm reduction principles into a recovery strategy for individuals coping with addictions to opiate-based drugs. By taking methadone as a daily treatment for physical withdrawal symptoms and cravings for opiates, individuals can focus their energy on building recovery skills and making changes towards re-establishing healthy patterns of living in all areas of their lives (5).

Saskatoon City Hospital offers a MAR program under the supervision of two physicians and the support of both one full- and one part-time counselor (soon to be increased to two full- and one half-time counselors). The clinic provides service to 170 clients, the majority of which (66%) are between the ages of 22 and 39³ (See Figure 2.8).

³ These clients include only those individuals accessing methadone treatment through City Hospital in Saskatoon. Two other physicians’ offices provide MAR in the SHR.
Enforcement

The Saskatoon Integrated Drug Unit (SIDU) is responsible for responding to drug-related crime in Saskatoon. A total of 799 adult charges and 91 youth charges related to heroin, cocaine, methamphetamine, cannabis or other drugs were made by SIDU in 2005 (Figure 2.9). The majority (53%) of both youth and adult charges were related to cannabis, however charges related to cocaine (a drug that is commonly injected) corresponded to 15% of all drug-related charges laid by SIDU in 2005. Charges related to other drugs (19% of all 2005 charges) may have included drugs that are injected, such as Dialudid, Morphine or Ritalin.
Figure 2.9: Drug-related Charges made by the Saskatoon Integrated Drug Unit, 2005
HIV & HCV Cases and Risk Exposure

Figure 2.10 below demonstrates a dramatic rise in new HIV cases in the SHR between 2005 and 2006. Investigation of this outbreak revealed that 42% of the individuals traced were listed as IDU contacts. Among the 73 named contacts of new HIV cases who participated in interviews, 80% of males (32) and 100% of females (33) reported current IDU with 75% of these individuals reporting sharing of needles or gear with others (2). The HIV outbreak and cluster investigation highlighted the need for a rapid, coordinated and comprehensive public health response that contributed to this strategic IDU plan.

HIV surveillance data from 2006 identified a total of 55 new cases of HIV, 30 of which were female (55%) (Figure 2.10). Between April 1, 2006 and March 31, 2007, 132 HIV individuals were identified as contacts of new HIV cases. Among these contacts, 45.5% were notified within 30 days and 23.5% were notified after 30 days. Overall, 69% of identified contacts were located, notified and encouraged to be tested for HIV. Among the 65 contacts who agreed to be tested, 37 (51%) were found to be HIV positive—all of whom were co-infected with HCV (6).
In response to an increase in the number of HIV contacts and cases, particularly among IDUs, PHS held a series of targeted HIV testing ‘blitzes’ in August and September of 2005, February of 2006, and November of 2006. During a blitz, efforts to test for HIV among high-risk populations are intensified. High risk populations include injection drug users and individuals identified as social, sexual or injection drug partners of a new HIV case. Figure 2.11 below shows the number of new HIV cases by month from January, 2004 to March, 2007. The data demonstrate substantial increases in new cases of HIV identified during months that correspond to HIV testing blitzes. The red line (or line without dots) is a three-month average and the blue line (or line with dots) is the monthly number of new cases reported.

![Human immunodeficiency virus infection](image)

Figure 2.11 New Cases of HIV Infection by Month
(SHR, January 2004-March 2007)

**Services for People Affected by HIV and HCV**
The most widely accessed programs and services for people diagnosed with or affected by HIV and HCV in the SHR include Persons Living with AIDS Network Saskatoon (PLWA), AIDS Saskatoon and the Central Saskatchewan Immunodeficiency Clinic and Hepatitis Program.

**PLWA Network**
(http://www.sasktelwebsite.net/plwaid/index.htm)
PLWA is a non-profit, community based organization serving the communities of Saskatchewan by providing services for those infected and affected by HIV. They provide *care* and *support* services for persons living with HIV/AIDS and their care providers, family and friends. PLWA provides support, self-help and care through drop-in centre or by phone to people living throughout the province.
Their purpose is to create a positive attitude and engender a feeling of hope for persons with HIV/AIDS as well as for their families, friends, and partners.

AIDS Saskatoon
(http://www.aidssaskatoon.ca/aboutus.html)
AIDS Saskatoon is a community-based, harm reduction organization, dedicated to providing support, prevention, and education services for people infected and affected by HIV/AIDS. They are the primary community-based AIDS service organization in central and northern Saskatchewan. The organization is a volunteer based, non-profit, charitable agency with a mandate to work with, and provide support for, those affected by HIV, and to educate for the prevention of HIV infection. They offer workshops and presentations in schools, community centres, workplaces and healthcare settings. Additionally, AIDS Saskatoon operates a local phone line and province wide toll-free information line. They also maintain a resource centre with lending library, video collection and research documents. AIDS Saskatoon works with and provides support for persons living with HIV infection their families, friends and loved ones in both group and one-to-one settings.

Central Saskatchewan Immunodeficiency Clinic (ID Clinic)—SHR
(Contact: 655-1783)
The Central Saskatchewan ID Clinic is an outpatient clinic intended to optimize HIV care by providing treatment, follow-up, counseling, immunization and education services to clients who test positive for HIV. The clinic also offers testing to clients’ partners and provides clients with links to Public Health, family physicians, community pharmacies, addictions programs, social services and community AIDS organizations. Housed at the Royal University Hospital, the ID Clinic is comprised of a team of physicians and nurses with specialized training in infectious diseases, including the care of HIV, who work together to provide service to clients. Clients access the ID clinic through referrals from family physicians, PHS, or other medical specialists from anywhere in Canada or the United States.

Central Saskatchewan Hepatitis Program—SHR
(Contact: 655-1840)
Also located at the Royal University Hospital, three physicians and a Hepatitis Nurse Clinician at the Central Saskatchewan Hepatitis Program provide care, information, support and educational materials to individuals infected with or affected by HCV. Clients access this program by referral from family physicians or public health nurses.
References


(5) Cameron B. Methadone Assisted Recovery Program, Saskatoon City Hospital--Overview and statistics. [Personal Communication: 4 May 2007].

(6) de Bruin P. Street Health Strategic Planning—Profile of Street Health Clients. [Personal Communication: 30 Apr 2007].
Part 3: Partnering around IDU--Integration & Planning Across Four Pillars

Introduction

This strategic planning framework aims to foster collaboration between stakeholders from various disciplines, organizations and communities under a shared vision to improve health and social outcomes for both IDUs and the greater community of Saskatoon. This report offers strategies for action based on stakeholder recommendations and research or best practice literature related to IDU. Four pillars (Health Promotion & Primary Prevention, Harm Reduction, Treatment & Recovery, and Enforcement) organize recommendations and actions around IDU for this integrated, collaborative strategy intended to promote the health and well-being of communities and establish an effective continuum of care for IDUs.

The vision of the Saskatoon IDU Strategy is of building partnership across and within different sectors under a common goal of promoting health and well-being for the community as a whole. Partnerships can exist between organizations, groups, agencies, individuals and disciplines. They generally have a common vision and shared resources and seek to improve or enhance access to services for both users and caregivers (1). Building partnership around IDU can facilitate collaborative and comprehensive responses, strengthen services and programs, and enhance best practices. Through the collaborative work of each pillar, we can create meaningful and effective partnership among existing programs and services, community organizations, communities and IDUs.

To understand what partnership is and how it works, this strategic planning document guides stakeholders through some difficult questions: What do collaboration, integration and planning across four pillars mean? How have others built effective partnerships? What key factors are driving the need for this partnership? What visions for the Saskatoon IDU Strategy do different stakeholders hold? How will we create our own effective, collaborative partnership? What roles will our partnership take on in this community?

Improved Health for Aboriginal People

Building partnership around IDU calls us to partner for improved health for Aboriginal people. Aboriginal people experience a disproportionate burden of IDU and the incidence of HIV infections is growing faster among Aboriginal people than any other group in Canada. Given Aboriginal people’s high risk for exposure to HIV, HCV and other blood-borne pathogens, it is important that partnership around IDU both acknowledge and respect the unique needs of this population and ensure active participation of Aboriginal stakeholders.
**Improved Communication and Collaboration**

Partnership around IDU also contributes to improved communication and collaboration between service providers. These improvements promote greater coordination of services and can improve access to services for a population that may experience marginalization, stigma or difficulty accessing traditional health and social services. In this context, the vision of the Saskatoon IDU Strategy also seeks to transform the delivery of care for IDUs by facilitating a seamless continuum of services that is coordinated, holistic, flexible and responsive to the unique needs of each client. Such a continuum of care would facilitate movement between services, starting from any point an individual might come in contact with the continuum to provide them with the resources and tools they need to make the best choices they can for their own health and well-being.

This section of the strategic planning document addresses different factors contributing to the need for partnership around IDU in the SHR. A review of the literature and best practices behind effective partnership approaches to service planning follows. The concept of a continuum of care is explored, including a detailed description of what levels of integration are needed to facilitate its development. Finally, a series of foundational recommendations or principles common to each of the four pillars is provided. These foundational recommendations are complementary to those that appear in other sections of the report. They are intended to stimulate dialogue and collaborative planning among stakeholders.
Best Practices for Integration & Planning

**Why partner around IDU?**

Partnerships are increasingly recognized as the key to successful integration and planning across diverse service providers and with diverse service users (1). Partnerships can be an efficient way of improving resource utilization while enhancing services and stimulating community participation. Generally, partnerships are hard work and take time to develop; but, they can achieve more than individual agencies working alone by contributing to building capacity and creating space for participative collaboration. Definitions of successful partnership commonly describe them as (1):

- Between organizations, groups, agencies, individuals or disciplines
- Focused on a common goal, vision or interest
- Sharing joint rights, resources and responsibilities through new structures and processes
- Facilitating access to services for users and care givers
- Autonomous and independent
- Promoting equality and trust

A number of key factors contribute to the need for partnership around IDU in the SHR. In 2004 and 2005, the SHR and the province of Saskatchewan experienced a major increase in the number of new cases of both HIV and HCV. Investigation of these outbreaks revealed that the majority of new cases of these infections were among IDUs and their sexual partners. The alarming increase in HIV and HCV infection in this population indicated that the needs of this population were not being met by services available to them. In 2001, the MHO brought stakeholders together in an Injection Drug Use Task Force (2). The consultation of stakeholders through this task force and the findings of investigations around recent outbreaks led to the idea of partnering to create a continuum of care.

Today, many services are already working together around IDU in the SHR. Steps towards stronger integration have been taken. Building a continuum of care for IDU integrates these strengths and provides opportunities to improve service delivery and contributes to the improvement of the health and well-being of both IDUs and communities. Through the process of investigating the HIV outbreak in Saskatoon (3) and subsequent consultation (4), stakeholders identified many gaps in services for IDUs. In the context of growing risks and increasingly complex needs of IDU, stakeholders recognized a need for improved coordination, communication and integration between the multiple services, agencies, community organizations, and communities connected to IDU in Saskatoon.

Because of the wide ranging and varied needs of this client population, no single agency had the technical capacity or resources to meet all the needs of individual clients, particularly over time or as their situation or circumstances changed.
Additionally, partnership around IDU aligns with both provincial and national strategies (5, 6). Interest in adopting a four-pillar approach has been demonstrated through stakeholder investment in developing the Saskatoon Youth Drug Strategy (7) and participation in working groups during strategic planning and consultation. Four pillar approaches are demonstrating success across Canada in cities such as Vancouver (8), Toronto (9), and Regina (10).

The alignment of local, provincial and national priorities combined with growing public health concerns makes partnership around IDU appropriate and timely. These contextual factors contributing making partnership appropriate are represented in diagrammatic form (Figure 3.1) below.

Figure 3.1: Contextual Factors driving the need for Partnership
**How do we build a successful partnership?**

The intersection of health needs of communities affected by or involved in IDU and the diverse, seemingly fragmented network of health and social support services is complex. There is increasing recognition that effectively promoting health and preventing disease requires the establishment of new ways of working, organizing and thinking about how services are provided. Table 3.2 provides a summary of key contributors and barriers to building successful partnerships.

Table 3.1: Contributors and Barriers to Success (1)

<table>
<thead>
<tr>
<th>Members of a successful partnership…</th>
<th>Partnerships can break down when…</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Share a common vision with obtainable goals</td>
<td>▪ Partnership is not the best approach to an issue</td>
</tr>
<tr>
<td>▪ Are representative of all stakeholders</td>
<td>▪ Collaboration is weak</td>
</tr>
<tr>
<td>▪ Are open to exploring new options for services</td>
<td>▪ Ideological differentials interfere with progress</td>
</tr>
<tr>
<td>▪ Have a strong level of mutual trust, respect and knowledge sharing</td>
<td>▪ Insufficient resources are available for support</td>
</tr>
<tr>
<td>▪ Maintain clear, consistent communication</td>
<td>▪ Members do not consider their participation as an ‘added value’</td>
</tr>
<tr>
<td>▪ Are flexible and adaptable</td>
<td>▪ Significant power imbalances exist</td>
</tr>
<tr>
<td>▪ Include service users’ perspectives</td>
<td>▪ Conflicts over cost-sharing are not resolved</td>
</tr>
<tr>
<td>▪ Invest in building effective relationships between stakeholders</td>
<td>▪ Stereotypes and prejudices about individuals or organizations prevent effective relationships from being created</td>
</tr>
<tr>
<td>▪ Create joint ownership</td>
<td>▪ Roles, responsibilities and accountabilities are unclear</td>
</tr>
<tr>
<td>▪ Explore and clarify issues of governance, roles and guidelines</td>
<td>▪ The process of building the partnership overwhelms the potential for realizing outcomes</td>
</tr>
<tr>
<td>▪ Focus on process and outcomes rather than structure and inputs</td>
<td>▪ Evaluation is inconsistent or infrequent</td>
</tr>
<tr>
<td>▪ Provide support and stability during organizational change</td>
<td></td>
</tr>
<tr>
<td>▪ Are committed to the partnership and its common vision</td>
<td></td>
</tr>
<tr>
<td>▪ Work across boundaries to engage with other stakeholders and disciplines</td>
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</tbody>
</table>
Partnerships involving community members and representatives of community-based organizations have been effective in making positive changes for programming for specific diseases (11), for community capacity development (12), and for creating organizational change (13). Evaluations of multi-sectoral, partnership approaches to HIV/AIDS services demonstrate effective coordination, open communication and commitment by stakeholders can contribute to more effective, holistic and accessible services (14).

Partnerships can also lead to successful collaboration between communities and universities (15, 16). The Community University Institute for Social Research (CUISR) is an example of an effective, ongoing partnership in Saskatoon. CUISR is a partnership between a set of community-based organizations and faculty and graduate students from the University of Saskatchewan that seeks to build the capacity of researchers, community-based organizations and citizenry to enhance community quality of life. This partnership has successfully contributed to building capacity through the development of research modules, participating in ongoing community-based research and providing resources to the public through their publications¹ (17).

Both the CUISR example and the contributors and barriers to successful partnership discussed here draw attention to the need to invest in the process of building partnership. This process is a process requires investment in six key dimensions: assessing the need for partnership; developing clear goals and a shared vision; ensuring balanced participation, ownership and commitment to the partnership; developing trusting relationship between stakeholders; defining roles and guidelines for participants in the partnership; and evaluating the partnership through ongoing monitoring and reflective learning. These “building blocks” for successful partnership are presented in Figure 3.2 below.

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¹ The CUISR website offers many useful resources and provides a detailed background about the institute and its development: http://www.usask.ca/cuisr/
Four Stages for Building Partnership

Building partnership for a common vision demands investment in both process and outcomes. The emergent nature of the process of partnership building is often described in stages or phases, beginning with creating a foundation that is elaborated into a more formal structure. The Nuffield Institute for Health provides a useful tool for assessing strategic partnerships. Their assessment is based on four stages for the process of building partnerships (18).

Stage 1: Preparation
- Agree on the purpose
- Negotiate individual contributions
- Decide what you will do
- Decide how you will do it

Stage 2: Assessment
- Circulate briefing materials
- Arrange meetings with partners to:
  - Familiarize with materials
  - Complete rapid appraisals

Stage 3: Analysis & Feedback
- Analyze individual responses
- Arrange feedback meeting to:
  - Share, discuss & interpret findings
  - Agree upon next steps

Stage 4: Action Planning

A
Assessment suggests partnership is working well. Partners need to consider how often to build in a regular review.

B
Assessment suggests partnership is working well in some parts but there are concerns about others. Partners need to decide how to address areas of concern.

C
Assessment highlights significant areas of concern which require urgent attention and a detailed plan of action.

Figure 3.3: Four Stages for Building Partnership
**Evaluating Progress**

Evaluating partnerships is important for ongoing assessments, identifying strengths and challenges, and monitoring outcome achievement (19). Such evaluation can be approached in different ways. The Nuffield Institute for Health Partnership Assessment Tool can be used for evaluation throughout the developmental stages of building partnership (18). The *Toolbox for Action* (See Appendix A) offers a rapid assessment tool to facilitate preliminary self-evaluation of the resources, strengths, interests and values of different stakeholders participating in each of the four pillars.

As the partnership evolves, more comprehensive and rigorous forms of assessment may be needed to accommodate the complexity of issues arising from the process of partnering (20). Comprehensive evaluation should assess the effectiveness, efficiency, equity, acceptability, accessibility, appropriateness, accountability, ethics, responsiveness, implementation and expansion of partnerships (21). Particularly important considerations for in-depth evaluation include careful consideration of context, stage of partnership and level of analysis (for example, organizational or project evaluation). Such a framework has been successful for evaluating the complexity of partnerships in England and contributed to understanding what factors inhibit or facilitate change (20).

Suitable forms of partnership research and evaluation may emerge from the recommendations provided in this document. The process of action research (Recommendation F-7), for example, might include ongoing assessment of the structure and process of creating partnership around IDU. As working groups consider the overall strategy and recommendations and being the process of building partnership, it will be important to incorporate evaluation and assessment in each step.
Partnering for Improved Health for Aboriginal People

Why is it important to focus on improved health for Aboriginal people?

Recognition of the disproportionate burden of IDU among Aboriginal people is an integral component of this strategy. Thirteen percent of Saskatchewan’s population is represented people who identify themselves as Aboriginal\(^2\) (22). In Saskatoon, approximately 80% of Street Health clients identify themselves as First Nations or Métis. This means that strategic planning around IDU must intentionally and respectfully address issues of cultural competency and ensure inclusive participation of First Nations and Métis stakeholders.

Across Canada, there are a number historical and contextual factors that contribute to the disproportionate burden of IDU among Aboriginal people. Aboriginal people experience higher rates of infant mortality and infectious disease, lower life expectancy, more frequently live in conditions of poverty, and have higher rates of unemployment than the Canadian population as a whole (23). These factors are inextricable from the contexts of systemic discrimination, racism, underdeveloped economies, social dislocation, loss of culture and the multigenerational effects of residential schools (24, 25). The challenges created by these contexts have been associated with higher rates of suicide, substance abuse and violence in Aboriginal communities (23, 25).

Compounding the disproportionate burden of IDU, the incidence of HIV infections is growing faster among Aboriginal people than any other group in Canada. Despite representing just 3.3% of the total Canadian population, 25.3% of reported new cases of HIV in Canada were among Aboriginal people in 2003 (26). Of all new reported HIV infections within the Aboriginal population in Canada in the same year, 60.1% were among IDU (26). Among populations of IDUs, the incidence of HIV is highest among Aboriginal people. Ongoing research from the Vancouver Injection Drug User Study revealed that, of 941 IDUs who entered the program between 1996 and 2000 without HIV, 21.1% of Aboriginal compared to 10.7% of all other IDUs became infected the virus by 2001 (24). Also unique to the epidemic of HIV among Aboriginal populations is the higher proportion of women infected with the virus and the lower age of infection than is found among non-aboriginal populations (24, 26).

Given the higher risk for Aboriginal people of becoming infected with HIV, HCV and other blood-borne pathogens and the large representation of Aboriginal people among Street Health clients, it is important that partnership around IDU both acknowledge and respect the unique needs of this population and ensure active participation of Aboriginal stakeholders.

\(^2\) Saskatchewan has the fourth highest proportion of Aboriginal people among Canadian provinces and territories. Nunavut, the Northwest Territories and the Yukon have the highest representation of self-identified Aboriginal people in Canada.
How can we partner for improved health for Aboriginal People?

As described earlier, partnerships are founded upon clear communication to create mutual trust, respect and knowledge sharing (1). Partnering for improved health for Aboriginal people in the context of IDU requires commitment to each of these components of effectiveness. Given the disproportionate burden Aboriginal people carry for IDU in the SHR, they are the key stakeholders in this strategy. As such, Aboriginal people are vital participants in the review and consideration of these recommendations, development of action plans, and ongoing process of partnership. The first step towards partnering for improved health for Aboriginal people is ensuring their voice is heard and respectfully woven into the steps each working group takes along the way.

In response the HIV/AIDS epidemic among Aboriginal people in Canada, a number of provincial and national advisory bodies and working groups have emerged. The Canadian Aboriginal AIDS Network (CAAN) is one such group, representing over 160 member organizations and individuals and providing a national forum for members to express needs and concerns. CAAN’s mission is to “provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside” (p. 2) (25). This network offers a series of valuable, frequently updated resources exploring issues related to HIV, AIDS and programming for Aboriginal people in Canada. Particularly useful is a framework outlining foundations for good practices in integrating HIV/AIDS prevention and harm reduction with addictions services and treatment for Aboriginal people (25).

The framework was developed through consultation with Aboriginal HIV/AIDS and Addictions service providers, elders and extensive review of relevant literature—including reports and manuals produced by Aboriginal organizations in Canada. The concept of ‘good practices’ emerged from this process in an effort to create a framework that acknowledges Aboriginal perspectives and de-emphasizes the hierarchical ranking of practices implied through the term ‘best practices’ (25). The framework offers stories to illustrate historical, cultural and contextual factors that contribute to the development of eight foundational principles. These principals represent good practices for addressing the links between addictions, sexually transmitted infections, and HIV/AIDS in Canada’s Aboriginal population (see full report for more details).
Table 3.2: CAAN’s Eight Foundations of a Good Practices Approaches

<table>
<thead>
<tr>
<th>Principle 1 -- Community-based Approaches</th>
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<tbody>
<tr>
<td>Recognizes that each community is different and has unique needs.</td>
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<tr>
<td>Effective STI and HIV prevention results from research and action within each Aboriginal community.</td>
</tr>
<tr>
<td>In Saskatchewan, 70% of Aboriginal people don’t live in reserve communities—cities are home to many Aboriginal people and the culture within these communities is distinct.</td>
</tr>
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<thead>
<tr>
<th>Principle 2 -- Holistic Care, Treatment and Support</th>
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</thead>
<tbody>
<tr>
<td>Considers physical, mental, spiritual and emotional wellness in prevention, treatment and support of Aboriginal people who struggle with addictions and who are HIV positive.</td>
</tr>
<tr>
<td>Effective STI prevention education needs to be culturally relevant and meaningful.</td>
</tr>
<tr>
<td>HIV/AIDS and addictions programs need to be able to identify and address root causes of behaviours that are high risk, including historical and contextual factors.</td>
</tr>
<tr>
<td>Holistic practices promote individual self-acceptance and require service providers to accept people without discrimination.</td>
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<tr>
<th>Principle 3 -- Community Awareness</th>
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<tbody>
<tr>
<td>Incorporates community-wide awareness and education about the connections between STIs, HIV, IDU and addictions in programming.</td>
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<thead>
<tr>
<th>Principle 4 -- High-Risk Group Education and Counseling</th>
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<tbody>
<tr>
<td>Education and peer counseling among high risk groups is key to preventing HIV through IDU or sexual transmission.</td>
</tr>
<tr>
<td>Expanding education for prevention to include addiction treatment centres can be very effective.</td>
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<tr>
<th>Principle 5 -- STI Screening as HIV Prevention</th>
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<tbody>
<tr>
<td>Screening for STIs is an opportunity to participate in HIV prevention and can be integrated into multiple services, including addictions treatment centres.</td>
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<tr>
<th>Principle 6 -- Harm Reduction for Addictions</th>
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<tbody>
<tr>
<td>Needle exchange programs, safe injection sites, and methadone treatment are demonstrated through research as effective harm reduction strategies.</td>
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<table>
<thead>
<tr>
<th>Principle 7 -- Healthy Sexuality</th>
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</thead>
<tbody>
<tr>
<td>Promoting healthy sexuality, particularly among Aboriginal youth, is critically important.</td>
</tr>
<tr>
<td>Healthy sexuality education needs to begin at a young age and be appropriate to each age and life stage.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Principle 8 -- Sustainable Funding, Resources and Advocacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding is an essential component of sustainable programming.</td>
</tr>
<tr>
<td>Advocacy by Aboriginal organizations must be accompanied by corporation among funding agencies.</td>
</tr>
</tbody>
</table>
Acknowledging & Incorporating Aboriginal Culture and Traditions

Culture, spirituality and traditional practices are strongly connected to health and well-being in Aboriginal communities. Spiritual connections within the community contribute to community cohesion and community members’ sense of belonging and self-identity. Recognizing the role of spirituality and traditional practice in Aboriginal health is integral to health promotion, primary prevention, harm reduction, and treatment and recovery services provided for people who identify with an Aboriginal community (27). Evidence suggests that as individuals learn about and connect with their traditional culture, their coping ability for negative encounters and events are strengthened (28).

CAAN’s study exploring needs and barriers to services for Aboriginal people living with HIV/AIDS provides strong support for the incorporation of spiritual and cultural dimensions into health-related services offered by community-based, provincial or federal programs (28). CAAN emphasizes that “the balance of the elements of mind, body, emotion and spirit in a person, as well as that person’s relationship with the earth and natural world, are necessary for good health” (p. 6) (28). Health is a balance and harmony within and among the four elements of human nature (physical, mental, emotional and spiritual).

As we move towards partnering for improved health for Aboriginal people, active participation of Aboriginal leaders and community members who understand and have experience with the spiritual practices and cultural traditions of their communities will be important for improving service accessibility and appropriateness and enhancing the cultural competence of service providers.
Partnering to Build a Continuum of Care

Vision of the Saskatoon IDU Continuum of Care
The Saskatoon IDU Strategy envisions an IDU continuum of care as a whole-systems approach to care that integrates a range of programs and services across the four pillars. This client-centered continuum acknowledges that many complex factors influence an individual’s decision to initiate drug use, engage in prevention or harm reduction practices, and access or follow through with treatment. Recognizing social determinants underlying IDU, the envisioned continuum of care connects support, health and addiction services, community organizations, and communities.

The continuum acknowledges that IDU is not the problem of isolated individuals, but rather embedded within the complexity of communities, families and social networks. Within this complexity, IDUs have needs that require collaboration, integration and coordination among stakeholders. Family, culture, social status dimensions, issues of marginalization, age and gender are important considerations of this vision.

This vision is of engaging in partnership to transform the delivery of care for IDUs, promote health and well being in our community, and create a seamless continuum of services to ensure IDUs and their families receive comprehensive, timely services. A coordinated, holistic and flexible partnership around IDU can respond to the unique needs of each IDU client and create opportunities for health promotion and harm reduction within the community as a whole.

Why a continuum of care?
Integrated models of care can successfully manage any number of health issues or illness (29). Building connections between services across a continuum improves the accessibility of services and allows for greater adaptability to community and client needs. A continuum of care is particularly important for clients coping with addictions who may transition back and forth between different stages of change (see Box 1—The Transtheoretical Stages of Change Model presented below). The continuum of care proposed for the Saskatoon IDU strategy requires integration across a number of different levels. Much of this integration will occur through the establishment of working groups under the four-pillar approach. Integration also requires coordination and improved communication across the four pillars. The literature and examples of integrated care models imply a need for service and program integration at the systems, point-of-delivery and client levels.

Over half of adults receiving HIV care in the United States present with mental health disorders and more than two-thirds report substance use (30). The co-occurrence of mental health and substance misuse combined with actual or perceived stigma against IDU can challenge effective communication between service users and service providers (29). The result of ineffective communication and interaction between service users and service providers result in poor health outcomes, contribute to drug resistance, and increase risk of other co-morbidities (29, 31, 32).
Box 1: The Transtheoretical Stages of Change Model

In 1982, Prochaska and DiClemente proposed a model for understanding how people cycle through different stages of changing their behaviour related to substance use. This model has become foundational for understanding how to provide supportive services to individuals using substances such as injection drugs. The model suggests that the stages are components of a fluid, dynamic process rather than fixed steps of achievement. As such, individuals frequently transition back and forth between the five stages and relapse is a normal part of the cycle.

1. **Precontemplation**: At this stage, the individual has no intent to change, often because of a lack of awareness of a need to change. Clients at this stage may present to harm reduction or enforcement services and, on occasion, to treatment and recovery services; however, they are not in a position to create or sustain change in their substance use.

2. **Contemplation**: Individuals at this stage develop an awareness of a need or desire to change and is considering the benefits and risks of taking action. Again, clients may present to a number of different services intended to support their change process, but they may not be ready to create or sustain a change in their substance use.

3. **Preparation**: As individuals decide they are ready to change, they enter a preparation phase in which they make plans to do so in the near future. Individuals may move back into a contemplation stage, but may also be ready to make active changes in their substance use.

4. **Action**: This is the point in the change cycle, individuals modify their behaviour, experiences or environment to create change. This stage is most frequently supported by treatment services, but also may engage aspects of harm reduction or enforcement.

5. **Maintenance**: Sustaining the change made in the action stage means maintaining the new behaviour. Individuals in this stage work to prevent relapse and consolidate the gains of changing their substance use behaviour. This stage is often supported by prevention and recovery services.

Prochaska and DiClemente have found that the majority of individuals continue to use, even after entering treatment programs. Their research has demonstrated that as many as 85-90% of people seeking substance abuse services are not in the action stage. This has major implications for their readiness or capacity to achieve and maintain changes as they participate in treatment or recovery services. Achieving sustained change requires flexible and adaptable support for clients, even as they repeatedly cycle through these stages of change. A continuum of care acknowledges these stages and their fluidity in an attempt to ensure clients have access to services that match where they are at with their substance use.

References


A review of evaluations of integrated HIV care revealed a series of service components that should be considered for the development of effective integration of care. These components include ensuring access to food and housing services, education around HIV/AIDS, self-help or support groups, case management, facilitation of transportation and child care needs and client advocacy. The review concludes that continuity of care needs to be promoted in holistic ways that use needs-based approaches and service integration, multidisciplinary collaboration, monitoring and evaluation and the
establishment of care pathways that allow access to core services through single entry points (29).

The VIP program, established in New York in the 1990s, is a useful example of an ongoing community-based model for integrated HIV and substance abuse services. VIP is designed to address substance abuse issues with HIV prevention and treatment services. Outreach services are tailored to support entry, engagement and retention in a continuum of care that offers access to a range of services through any one of multiple entry points. The program initially focused on HIV treatment, but has recently shifted this focus towards outreach and prevention as primary entry points. The continuum draws from harm reduction principles to offer client-centred services and facilitate entry into other programs, such as addictions treatment programs. The continuum builds bridges with enforcement through partnering with Drug Courts in the Bronx. The program is an example of how a continuum of care can be an effective, efficacious and beneficial strategy to improve access and coordination of services for HIV treatment and prevention (33).

Three Levels of Integration for a Continuum of Care

1. **Systems Integration:** *Brings management and support functions of various services and programs together in partnership.*

   Integration at the systems level requires partnership between stakeholders. Such partnership works through multiple levels to facilitate coordination and collaboration between services, agencies and communities who share a common goal (1). This integration is important because it contributes to creating a continuum of care that is inclusive, flexible and comprehensive. By facilitating integration at a systems level, fragmented programs and services are coordinated and accessibility for individual clients is improved. Once system-level integration is achieved, entry into the system at any point along the continuum of care becomes an opportunity to engage and assess the diverse needs of each client.

   Integration at the systems level requires a clear understanding of potential modes of entry into the continuum of care. Assessing what services are available and what services are needed is also critical to this level of integration. By bringing stakeholders together, systems level integration for a continuum of care can contribute to developing a common assessment and referral mechanism to ensure that all service needs are identified and clients are referred to the appropriate agency in a timely manner.
2. **Point of Delivery Integration**: Integrates multiple interventions or services through one delivery channel.

Contact with injection drug using clients can be infrequent or rushed. An integrated continuum of care capitalizes on any contact that may occur between service providers and clients, regardless of how brief, by providing multiple interventions through each delivery channel. Integrated care pathways ensure appropriate interventions are available at different points of contact by simultaneously providing core interventions.

The Centers for Disease Control and Prevention (CDC) recommend that such integration incorporate a range of pragmatic strategies that consider the IDUs life circumstances, culture and language, behaviors and readiness to change. For example, needle exchange services can be effectively integrated with education on safe injection practices, condom provision, HIV/STI testing and counseling, and referral for addictions treatment or other support services (34). Combining these key interventions in practical ways can reduce the transmission of blood-borne pathogens, including HIV/AIDS.

3. **Client-Centred Integration with a ‘Lead’**: Facilitates consistent client assessment and access to appropriate treatment or support services when they need them.

Integrating services at a client level means reorienting services to be centred around the unique needs of individual clients and their families. This is facilitated through the collaborative nomination of a ‘lead’ professional or agency. A lead professional or agency is an IDU service provider that facilitates navigation through the continuum of care with clients and their families. This facilitation ensures that clients get the right services at the right time. The role is supportive and enhances work that is already done by the various service providers in the SHR. By creating greater continuity and consistency for IDUs, the experience of accessing or receiving services can be greatly improved. Service providers and agencies also benefit through improved communication and coordination.

The lead may or may not be the first point-of-contact with the continuum of care, but rather the service provider who is best placed and has the necessary skills and resources to work with a particular client and family. The lead is a facilitator. This means that he or she is not responsible or accountable for the work of other service providers. Instead, their role is to facilitate access to or movement between services, advocate for clients and provide a consistent line of communication between clients and the various services they may need.

Facilitating the continuum of care with a lead professional or agency:
- Provides a consistency for IDUs and their families
- Coordinates services
- Reduces overlap and inconsistencies in service provision
- Creates partnership between service providers or agencies
- Creates partnership between IDU clients, families, communities and service providers
- Offers a venue for critical reflection on service availability, service gaps and opportunities for growth or change
- Promotes (re)integration of IDUs and their communities

Who takes on the role of the ‘Lead’?
Deciding who is most appropriate as Lead requires collaboration on a number of levels. First, some form of common assessment is needed\(^3\). Second, there is a need for common space to collaborate, share information and make recommendations for the most appropriate care. At this level, participating service providers and agencies also make decisions to allocate resources appropriately and ensure that no individual practitioner is facilitating an unreasonable number of clients. And third, commitment to ongoing collaboration is essentially to ensuring that the process is flexible and adaptable with client needs as the centre of focus.

This collaboration can be achieved through the establishment of multi-agency teams. Such teams meet regularly to collaborate around meeting the needs of new and ongoing clients. Choosing who will facilitate a client through the continuum of care is a collaborative decision of the multi-agency team. Teams need to know and understand the strengths, resources, and services provided by each participating practitioner and agency. As clients’ needs change, the role of the Lead may shift between practitioners so that whoever can offer the most relevant, appropriate support provides facilitation as the Lead. Through this multi-level collaboration, individual practitioners invest more time with fewer clients. Service providers benefit because of improved efficiency and clients benefit because they have accessible, consistent contact with an integrated continuum of care.

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\(^3\) See Recommendation F-2 (Long-term Strategies): The development of an Electronic Common Assessment Framework is critical to ensuring effective communication, facilitating information-sharing, and building continuity for individual clients entering the continuum of care.
Conceptual Framework

Figure 3.4 below captures the vision of the Saskatoon IDU Continuum of Care. This conceptual framework places information sharing between practitioners and services and ongoing community education on drugs and addiction as foundational to the continuum of care. Each of the four pillars (Health Promotion & Primary Prevention, Harm Reduction, Treatment & Recovery, and Enforcement) is placed on the continuum in conjunction with targeted groups. The conceptual framework highlights the roles of primary, secondary and tertiary prevention\(^4\) as they relate to each of the four pillars. Health promotion and primary prevention efforts, for example, are most targeted towards IDUs, youth, children and adults who do not use injection drugs. Activities under this pillar focus on population health promotion and target the community as a whole. Harm reduction, treatment and recovery, and enforcement efforts are targeted towards people at risk for using or IDUs with identified or complex needs. Under these pillars, efforts are targeted at individuals and call for case management and support.

Most importantly, care pathways exist between each of the four pillars and any possible entry point is connected and continuous so that an individual or group may enter the continuum of care at any point to receive services or access programs specific to their needs\(^5\).

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\(^4\) From a public health perspective of IDU, primary prevention aims to prevent blood borne diseases like HIV or HCV before transmission, secondary prevention involves early detection of a disease with possible interventions, and tertiary prevention attempts to reduce complications and deaths through treatment or rehabilitation of individuals who test positive for blood borne diseases (Shah, 2003).

\(^5\) This conceptual framework has been adapted from those proposed in the report, “Injection Drug Use in Saskatoon: Developing a continuum of care” and the continuum of care framework presented at the 2nd Annual Stakeholders Meeting in October of 2006 by Dr. Johnmark Opondo. Copies of both can be found in Appendix A.
Figure 3.4: Conceptual Framework for a Continuum of Care
Foundational Recommendations
The following recommendations have been developed from strategic planning, relevant reports and supporting literature. Each recommendation offers specific, concrete strategies for stakeholders to consider. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies require additional support or funding for implementation. Following the presentation of strategies, a list of expected outcomes is provided. Stakeholders are encouraged to consider these outcomes as a foundation for monitoring and evaluation to incorporate in the development of action-plans.

<table>
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<tr>
<th>Recommendations for Foundational Recommendations</th>
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<td>F-1</td>
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<td>F-6</td>
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**Recommendation F-1**

Improve coordination and communication between agencies and nominate lead for facilitating overall coordination of the strategy.

**Background**

Integrated strategies involving a four-pillar approach to drug and substance use (including harm reduction, prevention, enforcement and treatment) have been effective in a number of Canadian cities and are recommended as part of Canada’s national drug strategy (5). The work and leadership of Saskatchewan Tribal Council through the production of the *Saskatoon Youth Addictions Strategy* demonstrates the energy and commitment of various community actors to addressing issues related to drug and substance use in Saskatoon. This work focused on youth and identified the need for greater, more comprehensive treatment services and community involvement in a four-pillar drug strategy for Saskatoon (7).

The recommendations provided here are intended to contribute to the energy and momentum of the *Saskatoon Youth Addictions Strategy* (7), the October 2005/2006 stakeholder meetings, and the IDU in Saskatoon report (4). As a first step, SHR-PHS has taken leadership on developing a comprehensive four-pillar drug strategy for Saskatoon in collaboration with community partners and numerous stakeholders. The recommendations offered in this report incorporate those from other key reports with best-practices literature to develop a foundation from which the strategy can move forward.

Many agencies and organizations in Saskatoon offer a variety of services that are relevant to more than one pillar. The pillars presented in this report offer an organizational structure for the Saskatoon IDU Strategy. Each of the pillars is complementary to the others and is intended to be considered in concert with strategies from across the strategy. Because of the need for integration, the Saskatoon IDU Strategy will require some form of over-arching coordination.

**Suggested Strategies for this Recommendation**

**Short Term Strategies**

1. Establish working groups for each of the four pillars (Prevention, Harm Reduction, Treatment and Enforcement). As a working group:
   a. Review recommendations and suggested strategies, identifying gaps and assessing plausibility;
   b. Establish a time for a follow-up working session within two months of the Stakeholder Meeting;
   c. Identify a lead/chairperson for each pillar;
   d. Review the Toolbox for Action as a starting point to begin the process of planning and coordinating joint activities to address the recommendations.
   e. Discuss potential and ideal structures for the Saskatoon IDU Strategy, focusing on what kinds of over-arching coordination are needed to ensure progress and effective implementation of appropriate recommendations.
Long Term Strategies
1. Recruit and hire an IDU coordinator for the implementation of the Saskatoon IDU Strategy. The coordinator should have a clear, comprehensive understanding of the principles of population health; be familiar with stakeholders and the current strengths, challenges and concerns of both the IDU community and the community at large; and demonstrate creativity and leadership. The coordinator would be responsible for:
   a. Developing an action plan outlining objectives, activities, outputs, responsibilities, timeframe and potential sources of funding in conjunction with the various working groups.
   b. Liaising with stakeholders (including government, service providers, researchers, local business owners, drug users and the public at large).
   c. Facilitating cooperation and coordination between four pillars.
   d. Driving and coordinating implementation of the action plan.

Expected Outcomes
1. A coalition is established between community agencies and service providers engaging the IDU population with active working groups for each of the four pillars: Prevention, Harm Reduction, Treatment and Enforcement.
2. A coordinator is hired to facilitate the effective implementation of the integrated IDU strategy.
3. On-going evaluation shows that cooperation between stakeholders improves, providing a more holistic continuum of services for IDUs.
4. On-going evaluation shows that harm reduction strategies are more consistent and better integrated across services.

Potential Lead Agency or Partner Agencies
- Preliminary working groups established at the October 30th, 2006 meeting.
- Saskatoon Health Region—Public Health Services to facilitate development and dissemination of the strategic planning framework.
- Working groups to discuss the need for over-arching coordination and provide recommendations at the next stakeholders’ meeting.
**Recommendation F-2**

Collaborate across each of four pillars to ensure a comprehensive and individualized approach that addresses a broad range of client and community needs.

**Background**

In 2002, the office of the Medical Health Officer called for the establishment of an IDU Task Force to develop a framework for managing the multiple, often long-term, needs of intravenous drug using clients in the Saskatoon Health Region (SHR). Following this call, the SHR-Public Health Services led a study involving a wide range of stakeholders providing services relevant to IDU in region (4). In October 2005, the study’s final report was presented to stakeholders for their consideration and feedback. This meeting also served as a starting point for the establishment of a comprehensive, collaborative strategy that would coordinate services and contribute to developing a continuum of care for IDU in Saskatoon.

Saskatoon is home to a wide range of agencies and service providers whose clients include IDUs, many of which already work within the framework(s) of one or more of the four pillars presented in this report (4). These agencies provide services both directly (through drug addiction services, for example) or indirectly (through social support, safe shelter/housing, vocational/education training, financial assistance, or child-care, for example). Stakeholders report, however, that available IDU services are often fragmented and difficult to access in a timely manner (4). Additionally, stakeholders involved in the 2005 study felt that, despite the opportunities for coordination, collaboration between service providers in Saskatoon was limited. It was also acknowledged by stakeholders that the service needs for this client group far exceed what is currently available.

As the Saskatoon IDU Strategy evolves, four working pillars will be established to move recommendations into action. This strategy is envisioned:

- To be collaborative and participative, actively involving a broad spectrum of stakeholders (e.g. service providers, community-based agencies and organizations, communities and IDUs)
- To seek to improve coordination and communication between services
- To improve accessibility through the development of comprehensive supports for both individuals and communities
- To strengthen partnerships between NGOs and government by facilitating dialogue, strategic planning and sharing of resources
**Suggested Strategies for this Recommendation**

**Short-term Strategies**

1. Review the Saskatoon IDU Strategy report in its entirety, with special attention to the pillars that are relevant to you as an organization or individual.

2. Briefly review the IDU Directory, developed by the SHR-Street Health program.

3. Within each of the four working groups, discuss the report and its recommendations along with the IDU Directory. Discuss how well these documents:
   a. Define the spectrum of services available to IDUs in a way that allows distinct agencies and organizations to identify their own roles, responsibilities and accountabilities.
   b. Comprehensively address the concerns your specific agency, organization or community has with respect to IDU in Saskatoon.
   c. Offer realistic recommendations for moving forward into action.

4. Within each working group, consider the case study provided in Appendix A (Toolbox for Moving Forward) and discuss the following questions. As a working group, consider creating a position statement that incorporates the pillar’s responses to these questions:
   a. What is your first response to the case study? What do you think could have been improved to avoid this situation?
   b. How do eligibility criteria for entry into programs and services affect accessibility?
   c. How do eligibility criteria for entry into programs flex to meet the specific situational needs of intravenous drug-using clients?
   d. Do eligibility criteria for entry into programs allow clients to access essential harm reduction services? To recover?
   e. Are eligibility criteria for entry into programs easily accessible to service providers and IDUs outside of your organization or agency? If not, how can accessibility to these criteria improve?
   f. What changes are needed to improve communication between organizations, agencies and individuals to facilitate information sharing and coordination?
   g. What kinds of communication pathways between organizations, agencies and individuals are needed to ensure that IDUs have access to the services they need when they need them?
   h. How would a continuum of care address the concerns raised in the case study provided? What does that continuum look like? Where do you as an individual, organization or agency fit on the continuum?
**Long-term Strategies**

1. Building upon your working group’s responses to the case study questions presented in the Short-term Strategies above, create a proposed policy statement of referral guidelines for common addiction issues. Share this policy statement with the coordinator of the Saskatoon IDU Strategy or with the other pillars.

2. Create a Saskatoon IDU Strategy policy statement detailing referral guidelines to be distributed to all relevant service providers and agencies in the SHR.

3. Create a standardized, comprehensive Electronic Common Assessment Framework to serve as a consistent, structured tool that enables all service providers to assess client needs from first point-of-entry through referrals and ongoing care. The framework should incorporate:
   a. Detailed individual care plans
   b. Capacity to communicate and share key information between service providers around an individual’s care plan while maintaining and respecting confidentiality
   c. Ability to access policy documents and directory information
   d. Adaptability to emerging needs identified by users of the framework
   e. Ability to contribute to ongoing monitoring and evaluation

4. Explore options for establishing a website for the Saskatoon IDU strategy to provide electronic access to:
   a. The IDU directory
   b. The IDU Strategy Report (i.e. this document)
   c. The potential development of a treatment database (for example of such a database, see Ontario’s DART system at: [http://www.dart.on.ca/](http://www.dart.on.ca/))
   d. Distribution of educational materials relevant to each of the four pillars.
   e. Circulation of an on-line newsletter about local drug related activities and resources relevant to each of the four pillars.
   f. Development of an online self-assessment of drug addiction with tips and links to resources for ‘what to do next’.

**Expected Outcomes**

1. Stakeholders are able to identify and describe how they fit within the IDU continuum of care, as demonstrated by ongoing monitoring and evaluation of the Saskatoon IDU Strategy.

2. Communication and collaboration between agencies is enhanced, as demonstrated by ongoing monitoring and evaluation of the Saskatoon IDU Strategy.
3. Client assessment and identification of potential service needs is standardized and recorded in a consistent format that can be shared between service providers.

4. Referral mechanisms within the SHR are improved, as demonstrated by clients’ stories and reports of service effectiveness, efficiency and overall experience within the continuum of care.

**Potential Lead Agency or Partner Agencies**

- Saskatoon Health Region—Public Health Services facilitated the development of an IDU continuum of care conceptual framework, with active feedback and endorsement from stakeholders.

- Saskatoon Health Region—Public Health Services (Street Health) to develop IDU directory of services for endorsement by stakeholders.

- Preliminary working groups established at the October 30th, 2006 meeting with additional stakeholders as appropriate.
**Recommendation F-3**
Engage clients in the planning, development and implementation of all programs aimed at IDU.

**Background**
Stakeholders are “actors who have an interest in the issue under consideration, who are affected by the issue, or who—because of their position—have or could have an active or passive influence on the decision-making and implementation process” (p. 341) (35). In other words, stakeholders are people who are connected to a particular issue by providing, receiving, organizing or planning for policies, services or programs.

In the Saskatoon IDU Strategy, stakeholders are identified as those individuals or groups who interact with programs or services related to prevention, harm reduction, treatment or enforcement for drug-related issues. This group includes a wide range of service providers and community organizations.

Perhaps the most important stakeholders are the people for whom the continuum is designed: IDUs. Advocates for IDUs (including IDUs) call for greater involvement and ownership for and by IDUs in the development of policies and programs that are intended to promote health and well-being among this socially marginalized population (36, 37). Support for active involvement of IDUs in the development and implementation of the Saskatoon IDU strategy was echoed by participants interviewed for the ‘Developing a Continuum of Care’ (4).

**Suggested Strategies for this Recommendation**

**Short-term Strategies**
1. Using the network of agencies and organizations represented in each of the four pillars, develop a process for identifying and recruiting potential IDUs and other community members to participate in the working groups.

**Long-term Strategies**
1. Explore options for funding to provide appropriate compensation for travel, child care, and time commitments made by IDUs and other community members.

**Expected Outcomes**
1. At least one IDU and one other community member actively participates in each of the four working groups, as demonstrated by meeting minutes and reports produced by the groups.

**Potential Lead Agency or Partner Agencies**
- All stakeholders in each of the four pillar working groups to take collaborative responsibility for ensuring youth are incorporated in the planning, developing and implementation of programs.
Recommendation F-4
Engage youth in the planning, developing and implementation of all programs aimed at children and youth.

Background
Youth represent a population with unique characteristics and needs. Youth are identified as a key target group among other four pillar strategies (8-10) and among a number of provincial (6) and national (5, 38) recommendations surrounding IDU. The Saskatoon Youth Addictions Strategy is introduced by the powerful story of Delores Bird, an 11-year old girl who died of an overdose in November of 2004. The strategy document draws from both research and the experience of stakeholders to highlight gaps in services and provide a series of recommendations, also organized into four pillars, to improve services related to substance use (7).

The profile of youth and drug use in Saskatoon is described by the results of a survey conducted in 2004 by Saskatoon Communities for Children and the Community University Institute for Social Research. The survey included 552 youth aged 9-29. Results of this study illustrate high proportions of drug use among youth in Saskatoon: 64% of participants reported using substances—46% of whom reported using substances at least once per week (39). Another study exploring the relationships between HCV infection and IDU among 156 street youth in Saskatoon revealed that 32.3% of 186 participants had used injection drugs and 9.3% of 156 participants were infected with HCV (40).

Research of factors contributing to the initiation of injection drug use among Canadian youth draws further attention to the need to ensure the needs of youth are addressed by programming under each of the four pillars. A study conducted in Vancouver between 1996 and 2003 revealed that 38% of IDUs under 29 years of age initiated IDU by the age of 16 (41). Additionally, youth who initiate IDU in early adolescence were found to be at increased risk for HIV and HCV infection, high-risk drug use behaviour, sex work and criminalization (41-44).

Suggested Strategies for this Recommendation
Short-term Strategies

1. Using the network of agencies and organizations present in each of the four pillars (Prevention, Harm Reduction, Treatment and Enforcement), develop a process for nominating and recruiting youth representatives to participate in the working group.

2. Consider the recommendations provided by the Saskatoon Youth Addiction Strategy (7) in concert with those presented here.

3. Ensure that the consideration of each recommendation includes discussion and inclusion of actions to address specific needs identified by youth.
**Long-term Strategies**
1. Explore options for funding to provide appropriate compensation for travel, child care, and time commitments by youth representatives.

**Expected Outcomes**
1. At least one youth representative actively participates in each of the four working groups, as demonstrated by meeting minutes and reports produced by the groups.
2. Youth engage in less use of injection drugs and other substances, as demonstrated by continued surveillance of drug use in Saskatoon.
3. Prevalence of HCV and HIV infection among youth in Saskatoon decrease, as demonstrated by continued surveillance of both diseases in Saskatoon.

**Potential Lead Agency or Partner Agencies**
- All stakeholders in each of the four pillar working groups to take collaborative responsibility for ensuring youth are incorporated in the planning, developing and implementation of programs.
**Recommendation F-5**
Incorporate culturally relevant dimensions into strategic planning and programming aimed at improving the health and well-being of Aboriginal communities, including spiritual and traditional practices.

**Background**
Culturally relevant strategic planning means that policies and program or service-related decisions intended to promote health do so while incorporating adaptability and flexibility to cultural diversity.

Culture, spirituality and traditional practices are integral to the conceptualization of health and well-being in Aboriginal communities. These dimensions contribute to both community cohesion and community members’ sense of belonging and self-identity. Recognizing the role of spirituality and traditional practice in Aboriginal health is critical to program planning in health promotion, primary prevention, harm reduction, treatment and recovery services aimed at improving the health and well-being of Aboriginal peoples (27). As stakeholders partner for improved health for Aboriginal people, active participation of Aboriginal leaders and community members who understand and have experience with the spiritual practices and cultural traditions of their communities will be important for improving service accessibility and appropriateness and enhancing the cultural competence of service providers.

Cultural competency “acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to culturally unique needs” (p.26) (45). Research demonstrates that ensuring cultural competency can contribute to enhanced accessibility to and adherence to HIV treatment programs, particularly for minority groups (46).

A number of frameworks for ensuring cultural competency in policy and program planning are available (45, 47, 48). The frameworks highlight the potential opportunities for sharing and learning that stem from acknowledging the unique knowledge different cultural groups can contribute to the creation of more holistic, comprehensive programming. They also draw attention to how failing to strive for cultural competency in programming can result in policies that do not always meet the needs of a diverse population (45). Common components of these frameworks for cultural competence include community participation in the planning and development (49) and ensuring collaborative development of culturally-specific services (47, 48).

The Saskatoon Health Region is home to a culturally diverse population, representing both urban and rural communities, First Nations and Métis communities, new immigrants and refugees, among other distinct and celebrated cultural groups. This incredible diversity offers a number of opportunities and challenges for planning appropriate, effective public policies. The importance of incorporating multi-cultural perspectives into program planning is acknowledged by both the City of Saskatoon (50) and by the SHR (51).
Suggested Strategies for this Recommendation
1. Actively engage Aboriginal leaders and community members who understand and have experience with the spiritual practices and cultural traditions in each of the four pillar working groups.

2. Explore the incorporation of cultural and spiritual outreach to Aboriginal communities affected by IDU (including urban communities) into current health promotion, primary prevention, harm reduction, treatment and recovery, and enforcement efforts through the creation of employed positions.

3. Consider the frameworks for cultural competency provided in the background for this recommendation. As a working group, discuss the relevance of these frameworks to the working plan of your pillar. If the frameworks provided are not suitable to stakeholders in your pillar, engage in a process of identifying other models or frameworks that may be more appropriate (consult with a facilitator, if necessary).

4. Bring your pillars discussions about potential frameworks for cultural competency to the larger group for discussion. As a collaborative four-pillar strategy, adopt a common framework for cultural competence to serve as a foundational component of program planning and evaluation for the Saskatoon IDU Strategy.

5. Acknowledge the common framework for cultural competency into the mission statements of each working group.

6. Advocate for enhanced collaboration between researchers, service providers, and communities to promote the development of community capacity for cultural competency.

7. Work with researchers identified through Recommendation F-7 (Develop a Program of Research) to incorporate studies exploring demographic, cultural, spiritual and behavioural dimensions of IDU in the SHR.

Expected Outcomes
1. As an integrated, four-pillar strategy for IDU in Saskatoon, a common framework for cultural competency is identified.

2. Mission statements for each of the four pillars (Prevention, Harm Reduction, Treatment and Enforcement) acknowledge a common framework for cultural competency.

Potential Lead Agency or Partner Agencies
- Saskatoon Tribal Council

- All stakeholders in each of the four pillar working groups to take collaborative responsibility for ensuring cultural competency is addressed in plans for action.
Recommendation F-6
Develop a collaborative program of action-research for the Saskatoon IDU Strategy that facilitates the engagement of stakeholders in the process of developing best practices, monitoring and evaluating initiatives, and establishing effective working groups under each pillar.

Background
The Saskatoon IDU Strategy offers a number of unique challenges to the working group established to undertake these recommendations. Finding balance between differing perspectives, values and beliefs, and community needs is particularly challenging because of the diverse perspectives of stakeholders such as police, health care providers, public health, IDUs and the community. Furthermore, the expansion of research programs in substance use and misuse is supported by a provincial recommendation for the establishment of a Canada Research Chair in Substance abuse (6).

Action-research is an approach to participatory research programs or projects that can facilitate collaborative change between and within groups with diverse perspectives and contribute to community development. “Action research is the study of a social situation carried out by those involved in that situation in order to improve both their practice and the quality of their understanding” (p. 8) (52). This type of research engages stakeholders affected by a particular decision or policy in a process of critical reflection to make decisions and guide programming or planning (52). Using an action-research approach engages community members and key stakeholders in a process that bridges diverging interests and contributes to collaborative policy development and advocacy decisions. It is also useful way of examining how perceptions of enforcement issues change over time or of how changes in advocacy or enforcement efforts affect communities over time.

Action-research offers working groups an opportunity to develop leadership in synthesizing and integrating data (both qualitative and quantitative) emerging from the process and provide continuity through a research facilitator who is not an active stakeholder. This participative approach allows for advocacy and policy decisions emerging from other recommendations to be considered through a collaborative process of critical reflection and evaluation. In this way, an action-research program could contribute to the establishment of guidelines for best practices in each of the pillars and contributes to reducing significant gaps in available literature.
Suggested Strategies for this Recommendation

Short-term Strategies

1. Within each working group, complete the rapid self- or organizational-assessment tool (see Appendix A: Toolbox for Moving Forward). Review this assessment with your organization and share it with the working group, with a facilitator if necessary. Discuss what the assessments reveal about member organizations: What are the most urgent needs of the group? What are the resources available to the group? How does each organization or individual feel about the recommendations provided in this document? What recommendations are the most Important? Feasible? Uncomfortable?

2. Based on your working group’s discussions emerging from the self- or organizational-assessments, create a list of goals and objectives for the potential program of research that address the learning and team development needs of the working group.

3. As a working group, identify learning and team development needs of the working group (with the support of a facilitator, if needed).

4. As a working group, establish a list of desired experience and shared vision needed in a researcher/facilitator providing support and guidance for an action-research, participatory project.

5. In collaboration with other working groups, hold a stakeholders’ meeting at the University of Saskatchewan through an open invitation to faculty and graduate students (sent through mailing list) outlining the possibility of a research project and inviting any interested researchers to attend. The meeting should present/discuss:
   a. Goals of the potential research project
   b. Desire for an action-oriented, participatory approach
   c. Need for policy evaluation, both as baseline and on-going
   d. Interest in both project (i.e. thesis or dissertation) or long-term collaboration (i.e. faculty member)

6. Extend collaboration efforts to include the new School of Public Health (and other relevant departments) at the University of Saskatchewan.

7. Discuss the possibility of collaborating with other SHR research departments such as Population Health. Extend an invitation to these departments to attend the stakeholders’ meeting described above.

8. In collaboration with other working groups, identify potential researchers whose vision and experience fits the needs of stakeholders to pursue the development of a program of research.

9. Consider potential sources of funding for research, including CIHR and SSHRC, SHRF.
**Long-term Strategies**

1. In collaboration with other working groups and identified researchers, establish a project proposal in collaboration with a researcher identified in the meeting above.

2. Submit a Letter of Intent to potential funding agency, followed by fully developed research proposal.

3. Initiate program of research, with facilitation through identified researcher.

4. Addley (2005) recommended establishing a substance abuse research chair at the University of Saskatchewan, in order to increase research on substance abuse issues and best prevention and treatment protocols. Moreover, this it is hoped that this would focus data collection and evaluation so as to provide a more complete picture of substance abuse issues in the province in order to identify and appropriately address emerging concerns.

**Expected Outcomes**

1. Stakeholders learning and team development needs are met.

2. A researcher(s) with appropriate skills, experience and a complementary vision is identified and accepts to participate in the program of research.

3. A proposal for the program of research is developed and submitted to at least one funding agency.

4. Alternate sources of funding are sought.

5. A program of collaborative, participatory, action-based research is initiated with processes documented and evaluated continuously.

**Potential Lead Agency or Partner Agencies**

- University of Saskatchewan

- Each of the four pillar working groups to actively engage in evaluation and research activities, as directed by collaborative decision-making within the working groups.
References


(2) Opondo J. IDU Continuum of Care: Making it happen--2nd Annual Stakeholders Meeting. [Personal Communication: 30 October]; 2006.


Part 4: Health Promotion & Primary Prevention

Introduction

Health promotion and primary prevention include interventions that promote health and strive to prevent the initiation of IDU. Research evaluating prevention programs demonstrates their cost-effectiveness, with each dollar invested in prevention saving ten dollars in treatment costs (1).

The traditional model of disease prevention is based on three approaches: primary, secondary and tertiary prevention (2):

- **Primary prevention**, the major focus of this pillar, aims to prevent disease (or a high-risk outcome) before it occurs. In the case of injection drug use, primary prevention efforts are intended to reduce the risk that an individual will start using injection drugs.

- **Secondary prevention** reduces the complications of a disease by intervening as early as possible. This approach to prevention would include early detection of blood-borne diseases like HCV and HIV as well as other supportive initiatives intended to reduce other harms associated with injection drug use.

- **Tertiary prevention** efforts are supportive, rehabilitative or treatment directed at those individuals with a known disease. This may involve treatment and recovery services for addictions or supportive care for persons living with HIV/AIDS.

Expanding on the traditional model of prevention, primary prevention strategies can target different populations. Strategies may be directed at the population as a whole, at specific groups or at specific individuals (3).

- **Universal prevention** strategies consider the entire population at-risk for drug use. Strategies may be directed at national, local community, neighborhood, or school levels and can incorporate a variety of health promotion activities.

- **Selective prevention** strategies target sub-groups of the total population who may be at greater risk for initiating injection drug use. Higher-risk populations might include children of adults who use alcohol or other drugs, youth who have dropped out of school, youth from high drug use or low income neighborhoods or youth who have experienced abuse.

- **Indicated prevention** strategies target people who have started to use injection drugs, are at risk for continued use, and are exposed to the health risks associated with IDU. Indicated prevention aligns most closely with the principles of harm reduction.
The concept of health promotion is perhaps best captured by the Ottawa Charter (4). This model offers a series of actions for promoting health across a range of individual, community, and provincial or national policy levels. The marriage of population health and health promotion offers a valuable strategic framework from which to build programs or plan activities to improve the health and well-being of communities.

The Ottawa Charter has been integrated into a model for population health promotion to extend the concept to specific levels of action and to incorporate determinants of health (5). The model offers a who-what-how approach to planning around population health promotion (See figure 4.1) and is useful for considering as the working group under this pillar moves forward into action. On the far right side of the model, the five action strategies of the Ottawa Charter are listed. The top of the model represents the different targets for these actions: individuals, families, communities, sectors and systems, and societies. Social, structural, economic and individual determinants of health are listed on the front of the model as the ‘what’ to strengthen, enhance or target in population health promotion. The model is founded upon evidence-based decision making and an explicit recognition of values and assumptions that inform population health promotion actions (5).

Each of the three approaches to primary prevention (universal, selective and indicated) can be considered from the perspective of this model. As stakeholders consider the recommendations offered in this strategic planning document, it is helpful to keep the elements of health promotion and the determinants of health offered by the model in mind.
Figure 4.1: Model for Population Health Promotion—Who, What and How?
Best Practices in Health Promotion & Primary Prevention

Research and evaluation of health promotion and primary prevention programs demonstrate a need for comprehensive approaches that address all aspects of the model for population health promotion presented above (6, 7). In the context of this strategic planning framework, primary prevention seeks to prevent the initiation of injection drug use. Because of this, the main focus of primary prevention efforts is on children and youth. The community as a whole, including IDUs and their families, are also important target populations for health promotion and primary prevention.

Health Canada conducted a comprehensive review of the literature and research related to develop a set of best practices in the prevention of substance use among young people. They offer four principles of effective substance use prevention programs (7). These principles (Figure 4.2) are discussed in more detail below.

![Figure 4.2: Principles of Effective Prevention Programs](image-url)
1. Building a Strong Framework

Effective prevention programming builds on comprehensive partnerships, addresses risk and protective factors related to substance use, and ensures appropriate duration and intensity of programs (7).

Comprehensiveness

Ensuring comprehensiveness in prevention programming is particularly important because of the multiple, complex individual, family, school, community and society factors that contribute to substance use. Comprehensive partnerships link prevention activities to other, complementary efforts to promote holistic approaches, reduce duplication of services, and maximize the benefits of multiple points of entry into coordinated programming. For example, classroom instruction can be coordinated with peer helper programs, parent education, supportive school policies, mentoring programs for at-risk youth, and community awareness campaigns (7). Interventions can be coordinated at multiple levels and can incorporate groups who haven’t played a traditional role in substance use prevention, including urban planners, housing authorities, shopping mall management, and employment policy makers (8).

At a broader level, comprehensiveness needs to consider organizational policies and regional, provincial or federal regulations that contribute to preventing substance use (9). The enforcement of minimum-age drinking laws, for example, contributes to preventing the use of alcohol among youth. Addressing the basic determinants of health is another key to broad-level comprehensive prevention. Finding food, stable housing, job training, educational support, and personal counseling are daily challenges for youth living on the street (10). Street youth who are coping with addictions may have even greater needs and can often resort to crime as a means for supporting their drug use (11). Comprehensive prevention acknowledges these complex contexts, adapts to the needs of the targeted populations, and ensures that programs are coordinated across multiple levels.

Addressing Risk and Protective Factors

An important consideration in building a strong framework for prevention programming is an understanding of individual, family, community, and societal factors that may put someone at greater risk and those that build individual resiliency to initiating injection drug use (See Table 4.1 for examples). These factors can be considered risk and protective factors respectively. Effective prevention programs enhance protective factors while reducing risk factors for initiating the use of injection drugs (12). Because risk and protective factors are specific to any given community, it is important that prevention efforts address all forms of drug use (13), particularly those that are known to be circulating in the local community (12) and be tailored to the unique contexts and concerns of the community (14).
Table 4.1: Examples of Risk Factors and Protective Factors across Domains (15)

<table>
<thead>
<tr>
<th>Level of Influence</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Early aggressive behavior</td>
<td>Impulse control</td>
</tr>
<tr>
<td>Family</td>
<td>Lack of parental supervision</td>
<td>Parental monitoring</td>
</tr>
<tr>
<td>Peer</td>
<td>Substance abuse</td>
<td>Academic competence</td>
</tr>
<tr>
<td>School</td>
<td>Drug availability</td>
<td>Anti-drug use policies</td>
</tr>
<tr>
<td>Community</td>
<td>Transient neighborhoods</td>
<td>Strong neighborhood attachment</td>
</tr>
<tr>
<td>Society/Environment</td>
<td>Poverty</td>
<td>Strong social policy</td>
</tr>
</tbody>
</table>

*Duration and Intensity*

The third component of building a strong framework is ensuring that prevention programs are appropriate in both duration and intensity, as determined by the community’s unique needs and concerns (7). Success in prevention programs tends to erode over time, requiring regular re-evaluation of programming (16). Building prevention programming with five-year strategic plans may be one way to ensure that the community’s needs are met over time. The intensity of prevention planning is also determined by developing an in-depth understanding of the current state of substance use in a community. The better this is understood, the more prevention efforts can be tailored to meet the needs of the community.

2. **Striving for Accountability**

Accountable prevention programs are based on accurate information, set clear goals and objectives, build monitoring and evaluation into programs, and take steps to address sustainability from the beginning.

*Accurate Information*

Reliable, local information on the nature of substance use and the problems or challenges associated with it is a critical consideration in creating accountable prevention programming. The factors that contribute to substance use are complex and stem from a wide range of social determinants of health (15, 17), including stigma, marginalization and discrimination (18, 19). Regular, ongoing reviews of the nature and extent of substance use among the population of interest enhances program evaluation and can contribute to responsive prevention program planning (7).

*Goals and Objectives*

Clear, realistic, time-limited and measurable goals specific to particular populations or target groups are invaluable resources for facilitating evaluation and maintaining perspective in prevention programming. The prevention program may have an overall goal of preventing substance use among youth, but creating more specific objectives by age categories may be helpful for ensuring flexibility.
Monitoring and Evaluation
Both the process and outcomes of prevention planning and programming should be considered integral to accountability. Resources for conducting evaluations need to be planned for in advance and built into budgets and timelines.

Addressing Sustainability
Long-term sustainability should be incorporated into prevention planning and programming from the outset. This means that committed funding and resources will be consistently available. A formal work plan, timeline and budget that address defined responsibilities and long-term funding needs should be developed as part of the initial planning process for prevention programs (7). Sustainability is also promoted by ensuring that prevention programs meet needs identified by the community and involve active participation of a diverse range of stakeholders (20).

3. Understanding and Involving Young People
As emphasized earlier, youth are a major focus of prevention efforts related to injection drug use. Further to this, active involvement of youth is a foundational recommendation in this strategic planning framework (See Recommendation F-4). The psychosocial development of youth and youth perceptions of substance use are also important to understanding and involving young people in prevention planning and programming.

Psychosocial Development
Late childhood psychosocial development and the stages of adolescent development are important considerations for prevention programming. In late childhood, individuals develop confidence in their ability to learn and become diligent in acquiring new knowledge and skills. Successfully developing this confidence contributes to healthy identity formation as an adolescent. Conversely, when a child’s confidence in their abilities is not nurtured, they may feel inferior and develop a low sense of self-esteem and inadequate identity formation (21).

Healthy childhood development contributes to healthy adolescent and adult development. Prevention programs should start as early as preschool (22), enhance family bonding and relationships (23), and attempt to promote social-emotional learning in elementary schools (24) in an effort to promote healthy childhood development. At the middle, junior or senior high school levels, social and academic competence are important risk and protective factors among youth (25). Major life transitions (e.g. move to high school or parents’ divorce) can also influence healthy adolescent development and should be given consideration in prevention planning (26, 27).
Youth Perceptions of Substance Use
Achieving credibility is critical to successful prevention efforts aimed at youth. Programs need to be aware of the way in which young people view the benefits and risks associated with substance use. Youth may initiate substance use because of reasons similar to adults, such as stress relief; but there are needs specific to adolescent development that youth may feel are satisfied with the use of substances. These needs include taking risks, demonstrating autonomy and independence, developing distinct values separate from parental or societal authority, signaling entry into a peer group, seeking exciting experiences, and satisfying curiosity. It is important for prevention efforts to acknowledge perceived benefits of substance while working with youth to weigh these perceived benefits against perceived risks in an unbiased, judgment-free way (7).

Involve Youth
Involving youth in prevention efforts facilitates young people to see themselves as their own best resource for preventing and minimizing harmful effects associated with substance use. Youth can participate in data gathering, program planning and implementation, and monitoring and evaluation of prevention initiatives. Doing so enhances the possibility that prevention efforts will be effective (28).

4. Creating an Effective Process
Prevention programming involves a process of partnering, coordinating and planning. Ensuring successful prevention programs are developed through this process requires investment in a few key areas: developing credible messages, combining knowledge and skill development, building on interactive group processes, and giving attention to leader/teacher qualities through training.

Credible Messages
Messages delivered through prevention efforts can be explicit and implicit. It is important that both are considered realistic and credible by the targeted populations. Equally important is the delivery of the messages by credible messengers (7). Implied messages are translated through the structural approach to prevention. For example, excluding youth from prevention planning sends a message that their views are not valuable to the process. Additionally, drug information provided through prevention efforts must be scientifically accurate, objective, non-biased and presented without value judgment. The use of fear-arousing messages accompanied by incorrect or exaggerated information can generate skepticism, disrespect and resistance toward advice on substance use or any other risk behaviour (9).

Knowledge and Skill Development
Knowledge without skills does not provide the foundation individuals need to develop resiliency and other protective factors that prevent substance use. Skill development accompanied by accurate, objective information is therefore a central element for effective prevention programming. Skills such as decision-making, goal setting, stress management, assertiveness, and communication are important, broader life skills that
promote healthy coping for youth. Knowledge shared through prevention efforts should be practical and useful rather than theoretical (29).

**Interactive Group Process**
Engaging multiple stakeholders, include youth and youth-based organizations, in skill development activities and discussions can contribute to greater effectiveness in prevention programming. Prevention programs demonstrating the greatest effect use an interactive group process that involves peer-to-peer rather than instructor-to-youth activities (30). This type of programming incorporates creative activities such as role-play, simulations, service-learning projects, brainstorming, cooperative learning and peer-led dialogue. The effectiveness of interactive group process is demonstrated across drug types and across cultural groups (7).

**Leader/Teacher Qualities**
Selecting and training leaders or teachers who are competent, empathetic, and have an ability to engage youth has a direct impact on program effectiveness at the point of delivery. The teacher or leader needs to be accepted and respected by the target group, requiring teachers to be comfortable in a facilitative role. Training can be provided to teachers and leaders to demonstrate and discuss interactive teaching techniques. Alternatively, youth can serve as leaders or co-teachers and contribute to creating an environment appropriate for initiating discussion and exploring sensitive issues related to substance use (7).
Prevention Recommendations

The following recommendations have been developed from strategic planning, relevant reports and supportive literature. Each recommendation offers specific, concrete strategies for stakeholders to consider. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies require additional support or funding for implementation.

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**Recommendation P-1**
Strengthen programs which address the major social determinants leading to injection drug use.

**Background**
Drug use is a response to social breakdown, offering users a mirage of escape from adversity and stress. In order to numb the pain of harsh social and economic conditions, users turn to drugs, which in turn further pushes them down the social gradient. Some of the major social determinants that have been associated with IDU include: poverty; inadequate housing; lack of education and/or job training and employment opportunities; child abuse; family violence; involvement in the sex trade (31).

Social and economic circumstances strongly affect an individual’s health and life trajectory. The social gradient reflects material, physiological and psychological disadvantages and manifests in the effects of insecurity, anxiety and a lack of social integration. Thus in dealing with drug problems, not only is support and treatment for the user and family needed, it is also essential to tackle the patterns of social deprivation in which the problems are rooted. The social factors that breed drug use must be changed in order for other prevention, harm reduction and treatment services to be effective. The complexities of the social circumstances that generate addictive behaviors such as drug addiction must be targeted. Thus an effective IDU strategy must be supported by the broad framework of social and economic policy. Recognizing and acknowledging these concerns is an important first step in stabilizing the conditions that surround the lives of IDUs. The early identification of these socioeconomic determinants should be an important component of prevention programs.

Some social determinants that have been linked to IDU are:

- **Housing:** A major risk factor for IDU is a lack of affordable and safe housing. The IDU problems in Vancouver in 1995 were strongly associated with needle sharing linked to unstable housing (32). Many IDUs in Saskatchewan are a transient population, moving from city to town to reserve, and do not have safe, affordable and adequate housing (31).

- **Poverty:** There is a high association between people living in poverty and increased risk of IDU and acquiring blood-borne pathogens. This is particularly highlighted in the Aboriginal community (31).

- **Child abuse:** Studies have shown that men and women who use injection drugs often have similar histories including poverty, neglect, sexual and physical abuse and emotional problems (33-35).

- **Sexual abuse:** Survivors of sexual abuse often have the following characteristics: chronic depression, re-victimization (adults who were sexually abused as children are more likely to be abused in their adult relationships), sexual compulsivity, and dependence on substances (36). A study in Vancouver found that a history of sexual abuse was one of the strongest predictors of needle sharing among IDUs (32).
Family and Social Environment: A large number of children are growing up in deprived circumstances or dysfunctional families, where there is poverty, substance abuse by parents, family breakdown and physical, emotional and/or sexual abuse (37). Children coming from these backgrounds are more likely to be involved in deviant behavior in childhood and more likely to develop issues with substance abuse later (38).

Suggested strategies for this recommendation:

Short-term Strategies

1. Establish a working group under the prevention pillar with participants representing community, partner agencies and service providers.

2. Develop an IDU social determinants framework to guide planning decisions by collating information (quantitative and qualitative) about the social determinants associated with IDU (e.g. quantitative—proportion of IDUs who are homeless or have inadequate housing; qualitative—types of housing that are available to IDU).

3. Share the IDU social determinants framework with all members of the prevention pillar and then with stakeholders in other pillars.

4. Use the IDU social determinants framework to review programs that address the social determinants of health across all sectors and determine enhancement needs.

Long-term Strategies

1. Encourage all stakeholders to review policies, explore strategies and commit resources to address the major social determinants of IDU identified through the IDU social determinants framework.

2. Some strategies to start with and build upon are as follows:

   - Housing: Strengthen existing safe, adequate and affordable housing initiatives (e.g. QUINT).

   - Poverty: Target families living in poverty and provide them with opportunities for further education and job training (e.g. vocational programs, job skills training, or General Education Diploma education). Support should be provided in both urban and rural areas.

   - Child/sexual Abuse: Effectively coordinate and facilitate access to addictions agencies, physicians, mental health and other social services in a case management approach.

   - Family and Social Environment: Strengthen programs that enhance family bonding and parenting skills.
Expected Outcomes

1. The social determinants of IDU are widely acknowledged amongst all stakeholders and addressed as an encompassing part of an IDU strategy.

2. Programs which address the major social determinants leading to IDU are strengthened and enhanced according to local needs.

Potential Lead Agency or Partner Agencies

- CHEP
- City of Saskatoon
- QUINT
- Saskatoon Community Foundation
- Saskatoon Health Region–Public Health Services
- Saskatoon Regional Intersectoral Committee
- Station 20 West
- University of Saskatchewan
- YWCA Crisis Shelter
**Recommendation P-2**
Develop a social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and of injection drug users.

**Background**
The United Nations Programme on HIV/AIDS (UNAIDS) considers stigma and discrimination associated with HIV and AIDS to be the greatest barriers to the prevention of further infections; the provision of adequate care; and support and treatment (39). HIV/AIDS-related stigma is the devaluation of people living with or associated with HIV/AIDS, while HIV-AIDS discrimination is the unfair and unjust treatment of an individual based on their real or perceived HIV status (39).

In other words, stigma is the marking or labeling of an individual and discrimination is the resulting action or treatment of that individual. Stigmatization and discrimination against IDUs, people living with HIV/AIDS (PLWHA) and HCV positive people is common across all levels of society from within their own families to the community, health care workers and the government. Widespread HIV/AIDS stigma is further compounded by the layering of other stigmas such as the route of infection (e.g. IDU, sex work) and personal characteristics (e.g. ethnicity).

In cases where an injection drug user is HIV and/or HCV positive, the existence of co-stigmas presents as a particular challenge to be addressed (40). HIV positive drug users bear the double stigma of being involved with an illegal activity regarded as morally disdainful as well as having an infectious disease.

In the course of conducting the HIV cluster investigation in the SHR, it became apparent to PHS that there remains significant fear of discrimination and stigma associated with a new HIV diagnosis. The stigma and discrimination stands in the way of people protecting others from being infected with HIV. It also prevents people from coming forward to get tested for HIV. On a global level, this stigma and discrimination has been attributed to propelling the HIV/AIDS epidemic.

Studies across the globe have shown that stigmatization and discrimination is prevalent amongst health care workers and counselors. Medical treatment for HIV positive users can be delayed, refused or inadequate and breaches of confidentiality are common (41). Thus the fear of discrimination by the very system meant to treat and care for these marginalized individuals is a significant barrier to voluntary testing and/or disclosure of drug use. This can result in misdiagnoses or unfavorable drug interactions and is a significant barrier to reducing drug related harm.

Recent research has suggested a positive social function of stigma within the population at large (40). Researchers present stigma as an enduring social process which results in negative outcomes for some individuals but in some circumstances may be a positive driving force at the population level. An example of this is the apparently successful orchestrated stigmatization of smoking (social marketing campaigns) which appears to have reduced the population burden of morbidity and mortality attributed to tobacco.
The IDU Continuum of Care Report recommends that all stakeholders need to support community ownership of drug abuse issues and their participation in change, through the use of age, gender and culturally appropriate and diverse media strategies (following successful campaigns such as tobacco, drinking and driving) (42).

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Review current social marketing campaigns about HIV/AIDS, HCV, IDU in the SHR and nationally.
2. Plan a social marketing campaign for the SHR by identifying:
   a. Target audience (e.g. IDU; healthcare workers; general public).
   b. Intent of message (e.g. reduce stigmatization and discrimination amongst healthcare workers; reduce fear of voluntary testing and disclosure of drug use amongst IDU). Set clear objectives for each message delivered.
   c. Appropriateness of message (e.g. age, gender, culture appropriate). Use models appropriate for target audience (e.g. avoid the use of authority figures to target high-risk youth, instead use young models who appeal to them and who they can relate to) (43).
   d. Available resources in the community and from service providers.
3. Explore the potential for establishing a drug users groups in the SHR to develop a response from the ground up and enable users to advocate for their own needs.
4. Develop educational resources for general distribution, such as pamphlets or information sheets, to raise community awareness about the realities of social determinates of health and their role in contributing to IDU.

**Long-term Strategies**

1. Build upon existing campaigns to include the following elements:
   a. Promote IDU as an addiction to drugs, a condition with complex physical, social and psychological subtexts; a treatable biomedical and psychological disease. By adopting the stance that drug addiction is often associated with mental illness, it shifts IDU from a moral focus to a health focus (44). This reduces the associated stigmatization and discrimination of IDUs and the illegal status of their activities.
   b. Constantly promote the ideals that IDUs can recover and have fulfilling lives without drugs, by actively capturing and disseminating stories about successful recovery (e.g. National Drug Awareness Week, local newspaper).
   c. Efforts should be made to change the perception of HIV and HCV from being fatal diseases, to being chronic diseases. Promote awareness of new developments in HIV/AIDS treatment.
d. Foster consistent public education which clearly explains HIV transmission risk and its non-discriminatory nature.

e. Use positive images of people living with AIDS (PLWA) and encourage and support them to tell their story.

f. Use syringes, condoms and other preventive health tools in the context of a social marketing strategy that links behavior change or correct behavioral information to services.

F Support recovering addicts to talk about their life experiences in settings such as talks at schools, interview in local newspaper/radio.

h. Use a diverse range of information, education and communication materials (IEC) such as television, radio, newspaper, art exhibitions, printed materials.

2. Develop in-service training for service providers of IDUs in areas such as the underlying social determinants of IDU, principles of harm reduction, and prevention strategies.

3. Work with policy makers to advocate for stronger and broader policies against stigmatization and discrimination.

4. Continue a consistent and sustained marketing campaign over time as stigma and discrimination are deeply rooted.

Expected Outcomes

1. Increased access by IDUs to testing and treatment facilities and uptake of harm reduction techniques.

2. Improved HIV contact tracing and partner notification by PHS.

3. Improved quality of services for IDUs by all stakeholders.

Potential Leading agency or Partner Agencies

- AIDS Saskatoon
- City of Saskatoon
- Persons Living with AIDS (PLWA)
- Saskatchewan Health
- Saskatoon City Police
- Saskatoon Health Region—Public Health Services
- Saskatoon Regional Inter-sectoral Committee
Recommendation P-3
Develop a school-based prevention program from kindergarten to grade 12.

Background
Research demonstrates that early risk factors for drug abuse include aggressive behavior, poor social skills, and academic difficulties (22, 45). In this context, establishing prevention programs that intervene as early as preschool and continue throughout the school years is an important and effective approach for addressing related risk factors at different stages of development (15).

School-based prevention programs generally focus on enhancing skills such as building peer relationships, practicing self control, developing coping skills, practicing drug refusal skills, building appropriate social behaviors, and building peer relationships. Opportunities to enhance such skills are recommended for integration within the school’s goal of enhanced academic performance (15).

Effective school-based programs are comprehensive, offer early intervention, project a clear no-use message, employ appropriate strategies for different populations, and implement their program within a broader community-wide prevention effort (46). A school-based drug prevention program includes the educational programs, policies, procedures and other experiences that contribute to achieving broader health goals of drug use and abuse prevention (47). Components of an effective school-based drug prevention program may include:

- Development and delivery of formal and informal curriculum in health to equip students with information about drugs, the life skills required to deal with situations without resorting to drug use, the skills to resist pressure to use drugs, and an understanding of what drugs are.
- Promotion of a safe and healthy school environment.
- Clearly communicated policies and procedures that provide care, counseling and support for all students and promotes a cooperative partnership between students, staff, parents, related professionals, agencies and the police, thus facilitating a safe and supportive school environment.
- Strategies to ensure that all members of the school community contribute to and support school policies and procedures relating to drug matters.
- Professional development and training for staff involved in drug education and school policy enforcement.
- Provision of appropriate health services and support for students, including appropriate information and support for parents, particularly those with children involved in drug use.
- Involvement of family and the community in the planning and delivery of programs.
- Continuous monitoring and evaluation of the school’s approach to drug abuse prevention and the management of drug use incidents.
Drug prevention curricula based on the Social Influence Model (SIM) has shown to be the most promising prevention approach to date in changing student drug-use attitudes and behavior (46). This model is based on the premise that youth who abuse drugs do so in response to social pressures from peers, family, and the media, as well as from internal pressures such as the desire to be ‘cool’ and popular. Programs based on the SIM model provide information on the health and social consequences of drug abuse as well as life skills and resistance training to arm students with the skills to resist pressures to use. In particular, peer-led prevention programs are demonstrated to be highly effective.

In the SHR, only two service agencies (The Saskatoon Public School Division and the Regional Intersectoral Committee on Human Services) report involvement in universal primary prevention activities, mainly in the form of health education in selected schools (48). Public health nurses visit schools in the SHR to discuss tobacco and alcohol prevention; however, they often do not discuss details about illicit drugs due to limited space in the school health curriculum. Some public health nurses reported that they have little experience with teaching about some of the illicit drugs or about injection drug use among youth.

Participants at the Stakeholders Meeting in October, 2005 supported the development of an integrated, kindergarten to grade 12 school-based prevention program. Stakeholders indicated that the program should include active parental involvement and the use of facilitators with life experience (recovering drug users). Suggestions of issues to include a school-based curriculum included:

- Health risks associated with injection drug use.
- Social influences related to initiation of injection drug use.
- Programming with positive role models.
- Skill building and resistance training.

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Review current school-based drug prevention curriculum, teaching resources and school drug policies in order to identify areas of strength and areas requiring enhancement.

2. Review models of successful school-based drug prevention programs and principles. The following reports are suggested as a starting point:
   d. SAMHSA Model Programs: Matrix of model programs at a glance (www.modelprograms.samhsa.gov/matrix_all.cfm).
3. Explore the possibility of linking school-based drug prevention programming to HIV/AIDS awareness programs which are mandated by Saskatchewan Learning.

**Long-term Strategies**

1. In collaboration with Saskatchewan Learning, develop a suitable school-based education program model for kindergarten to grade 12 for schools in SHR.

2. Develop and incorporate a monitoring and evaluation component to assess impact and effectiveness of the school-based education program.

3. Particular areas of focus for each school level could include:
   
a. **Kindergarten level**: develop prevention programs with a focus on risk factors for drug abuse such as aggressive behavior, poor social skills, and academic difficulties (22).

b. **Elementary School level**: develop programs with a focus on improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Skills to be emphasized include: self-control, emotional awareness, communication, social problem-solving and academic support particularly in reading (49). A key area to be addressed in this age group is reading ability, as evidence shows that the inability to read by the third or fourth grade is a major risk factor for school failure, which in turn is strongly associated with drug abuse (50).

   c. **Middle/Junior High and High School level**: develop programs with a focus on increasing academic and social competence. Skills to be emphasized include: communication, self-efficacy and assertiveness, peer relationships, study habits and academic support, drug resistance skills, reinforcement of anti-drug attitudes, and strengthening of personal commitments against drug abuse (25, 51).

4. Prevention planning efforts should particularly focus on fostering self-esteem in the 7-12 year old age group as non-injection drug use often commences between 10 and 14 years of age, with users moving onto IDU between the ages of 15 and 19 (52). Prevention efforts should also target key risk periods for drug abuse during major physical and social transition periods (e.g. puberty, moving, divorce, entry into elementary/middle/high school, or leaving home (15)).

5. Build interactive and peer-led techniques into program delivery. Meta-analysis studies have shown interactive techniques such as peer discussion groups and parent role-playing to be far superior to non-interactive methods (51).

6. Provide professional development for teachers and public health nurses in IDU and other related substance abuse issues.

7. Advocate for a uniform policy in the SHR on substance use and possession on school property.
**Expected Outcomes**

1. A research-based school-prevention program model is developed for schools in SHR from kindergarten to grade 12. This would include teacher training, school drug policy, community partnership.

2. Youth and children in the SHR have consistent access to reliable information about the risks of drug use.

3. Drug use among youth and children in the SHR decreases, as demonstrated by ongoing research and evaluation of strategies employed.

**Potential Lead Agency or Partner Agencies**

- Communities for Children
- EGADZ Youth Centre
- Greater Saskatoon Catholic Schools
- Royal Canadian Mounted Police—Drug Awareness
- Saskatchewan Health
- Saskatoon Health Region—Public Health Services
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Public Schools
- Saskatoon Regional Intersectoral Committee
- Saskatoon Tribal Council
- White Buffalo Youth Lodge
**Recommendation P-4**
Enhance skill and esteem building programs for families.

**Background**
Early childhood development within the family environment is considered one of the most crucial influential factors affecting behaviour later in life. A variety of factors can impede family bonding and interfere with the sense of security required for normal healthy development. Early risk factors associated with drug abuse in the family domain include (15):

- Lack of mutual attachment and nurturing by parents or caregivers.
- Ineffective parenting.
- Chaotic home environments.
- Lack of a significant relationship with a caring adult.
- A caregiver who abuses substances, suffers from mental illness, or engages in criminal behavior.

Conversely, families can serve a protective function against drug abuse when families (15):

- Can create strong bonds between children and their families.
- Can support active parental involvement in a child's life.
- Offer supportive parenting that meets financial, emotional, cognitive, and social needs.
- Can set clear limits and consistent enforcement of discipline.

Critical developmental periods may heighten the role of risk or protective factors. For example, mutual attachment and bonding between parents and children occurs during the developmental stages of infancy and early childhood. If it does not occur during this period, strong positive attachments are unlikely to develop later in life. Prevention programs must therefore capitalize on these critical periods to solidify the bond between parents and their children by offering family-based programs.

The enhancement of social and personal skills for families within a supportive environment can strongly influence attitudes and promote behaviors that are consistent with a healthy lifestyle. Family-based prevention efforts may include a focus on providing support for the development of (15):

- Family communication skills.
- Developmentally appropriate discipline styles.
- Firm and consistent rule enforcement.
- Other family management skills.
- Emotional, social, cognitive and material support.
Suggested strategies for this recommendation:

**Short-term Strategies**

1. Conduct an environmental scan of existing family and parenting programs in Saskatoon to identify strengths and areas for enhancement, with emphasis on meeting the needs of high-risk families or families experiencing crisis.

2. Review the universal family-based program *Strengthening Families Program for Parents and Youth 10-14* and determine its applicability for Saskatoon. This program has demonstrated positive results and has been successfully replicated across different ethnic subgroups in both urban and rural settings (53).

3. Strengthen partnerships with local schools, day cares, play schools, churches and health agencies as venues for the dissemination of information and the provision of education about substance abuse to parents of young children.

**Long-term strategies:**

1. Based on the results of the environmental scan, develop a suitable and sustainable family-based program model for Saskatoon.

2. Ensure that the family-based program includes a monitoring and evaluation component to assess impact and effectiveness.

3. Components of the family-based program could include:
   a. Intensive support to substance abusing parents to improve their parenting skills and substance abusing behavior.
   b. Youth and family recreation programs with activities that involve the whole family (54). An emphasis should be made on family bonding through providing opportunities for joint parent-child participation in activities (55). Some programs have used incentives such as meals, transportation, small gifts, and sponsoring family outings, due to the difficult nature of retaining family involvement (56).
   c. Selective prevention to target programs at particular high risk groups (e.g. families coping with poverty, children of known drug users) that are implemented by those who have experienced the same challenges.
   d. Adequate and ongoing support to youth who drop out of school to help them complete their education and find meaningful employment.
   e. Efforts to ensure families are safe places through addressing issues such as domestic abuse, parenting support, and early learning and childcare. Programs should offer: parenting skills; practice in developing, discussing and enforcing family policies on substance abuse; as well as training in drug education and information (54).
   f. Efforts to improve family communication through interactive techniques such as modeling, role-playing, and rehearsal (55).
g. Efforts to strengthen family bonding through skills training on parent supportiveness of children, parent-child communication, and parental involvement (57).

h. Efforts to enhance parents’ monitoring and supervision skills through training on rule-setting, techniques for monitoring activities, praise for appropriate behavior and moderate, and consistent discipline that enforces family rules (57).

i. A skill building approach that supports the development of positive identity and enhanced self-esteem with elements such as: skills to build a healthy lifestyle, tools for anger and stress management, and assertiveness skills (15).

j. Informational sessions in various formats such as mini-workshops, creative exercise, art therapy, psycho-drama, individual counseling, group work and family therapy in a variety of venues (15).

k. Efforts to incorporate culturally appropriate teachings about traditional skills, practices, and ceremonies (58).

Expected Outcomes

1. A research-based family prevention program model is developed for Saskatoon that is built upon existing initiatives.

2. Families in the SHR have consistent access to the information and services they need to build effective parenting skills and create healthy family living environments.

Potential Lead Agency or Partner Agencies

- Communities for Children
- Family Healing Circle Lodge
- Project Hope
- Saskatoon Health Region—Public Health Services (Parenting Program)
- Saskatoon Tribal Council
- Teen Challenge Saskatchewan
Recommendation P-5
Enhance positive community-based prevention programs for at-risk youth.

Background
At-risk youth are those likely to experience drug use, truancy, school problems or violence during their childhood or adolescence. By adolescence, children’s attitudes and behaviors are well established and not easily changed. Prevention efforts must therefore start early because delaying intervention until adolescence may make it more difficult to overcome risks.

Research highlights that key risk periods for drug abuse occur during major transitions in children’s lives. For example, risk periods may include times when youth experience changes in physical development or in social situations (e.g. parents divorcing, moving, or entering high school). These transition periods represent times of heightened vulnerability for the initiation of high-risk behaviors, including initiation into drug use (15).

Positive community-based prevention programs have been shown to be highly successful in reinforcing the value of youth in the community. It is essential to explore ways of reaching youth who have dropped out of school, lack adequate and positive adult supervision and who do not have access to positive community activities. Positive community-based prevention programs can support at-risk youth to develop personal and social skills that are inconsistent with substance abuse.

A number of service providers in the SHR (Street Health Program, AIDS Saskatoon, Egadz, and Saskatoon Gay and Lesbian Health Services) provide health education to individuals and groups with identifiable risk factors that predispose them to problematic substance use. Their experiences and programs should be used as the basis for enhancing positive community-based prevention programs for this population.

Suggestions of ways to approach recommendation:
Short-term Strategies
1. Review existing programs for at-risk youth in Saskatoon and identify strengths and areas for further enhancement.
2. Review Canadian programs for at-risk youth and determine applicability to Saskatoon.
3. Strengthen existing programs such as Saskatoon Community Youth Arts Programming (SCYAP), Core Neighborhood Youth Co-op (CNYC), Saskatchewan Native Theatre Company, and after school activities (sports, drama, arts and music).
4. Combine efforts with the recommendation on school-based prevention programs (recommendation P-4) to target the general school population at key transition points. Such interventions do not single out high risk populations and hence reduce discrimination and stigmatization of at-risk youth and promote bonding to school and community (26).
5. Enhance street outreach programs designed to prevent at-risk youth who are currently using drugs from moving onto more harmful drugs or drug use methods.

**Long-term Strategies**

1. Enhance youth recreational activities by offering positive community spaces to at-risk youth to provide a sense of belonging, support system, mentorship opportunities, and other healthy, fun and meaningful activities.

2. Program peer-led interventions (59) into the development of alternative programs (60).

3. Advocate for the delivery of prevention programs by a trusted leader and/or former IDUs, whom youth respect, in a mentored and supported environment (61).

4. Diversify implementation of prevention programs to reach at-risk youth through multiple channels such as schools, clubs, faith-based organizations and the media. Prevention messages should be consistent across all settings to reinforce objectives and influence peer norms (62).

5. Explore a combination of network, peer-driven and individual approaches to changing behaviors within peer groups amongst at-risk youth (63).

6. Offer alternative events that focus on building a culture of peer norms against the use of alcohol and illicit drugs (63).

7. Enhance and expand initiatives that create vocational or skills training for youth, such as those currently offered by the Core Neighborhood Youth Co-op and the Saskatoon Community Youth Arts Program.

8. Ensure that the role of adults participating in youth-based community development is of affirming the work done by youth. Adult volunteers can be a positive presence for youth, letting them know that there are adults in the community who care about them and are willing to contribute their time and energy (61).

9. Adopt an empowerment model in prevention programming to focus on youth strengths rather than deficits. Such an approach also promotes collaborative prevention efforts and fosters capacity and skill development among both youth and their communities.

**Expected Outcomes**

1. Opportunities for youth to become actively involved in alternative activities within the SHR grow, as demonstrated by the enhanced capacity and youth participation in programs such as SCYAP or the CNYC.

2. At-risk youth will be channeled into more positive community pursuits and have a greater sense of belonging in the community.

3. Drug use among youth and children in the SHR decreases, as demonstrated by ongoing research and evaluation of strategies employed.
Potential Lead Agency or Partner Agencies

- Communities for Children
- Core Neighborhood Youth Coop
- Greater Saskatoon Catholic Schools
- Saskatoon Community Youth Arts Program
- Saskatoon Health Region—Public Health Services (Healthy Growth & Development)
- Saskatoon Public Schools
- White Buffalo Youth Lodge
References


Part 5: Harm Reduction

Introduction

Harm reduction principles are foundational to public health and community-based programming intended to meet the needs of injection drug users (1).

Harm reduction:
- Is an approach or strategy that aims to reduce the negative consequences of drug use, rather than to eliminate drug use (2).
- Can involve programs or policies that are designed to reduce drug-related harm without requiring abstinence or cessation of drug use (3).
- Promotes incremental improvements in the behaviors of injection drug users that are practical, achievable and ultimately lead to benefits for both users and communities.

Much variability exists in the types of activities, policies and programs that fit within a particular strategy; however, there are underlying conditions that must be met if these are to be classified as harm reduction strategies. These three conditions are: the setting of a primary goal to reduce harm rather than drug use, inclusion of strategies to reduce the harm for people who continue to use drugs, and employment of strategies aiming to demonstrate a net reduction in drug-related harm as an outcome (4). Additionally, the harm reduction approach offers a set of underlying principles to guide the development of policies or strategies aimed to reduce the harms associated with injection drug use.

<table>
<thead>
<tr>
<th>Harm reduction strategies should:</th>
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<tr>
<td>Provide a practical alternative focusing on the consequences of potentially harmful behaviours rather than on the morality of the behaviour (2) (meeting clients’ needs ‘where they are at’).</td>
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<tr>
<td>Accept alternatives to abstinence (such as needle exchange or methadone programs) and promotes intentional efforts to reduce barriers to treatment options (2).</td>
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<td>Consider drug use as a health and social issue with diverse determinants of health (5).</td>
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<td>Respect the rights and dignity of people who inject drugs (5).</td>
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<td>Provide accessible, appropriate services that involve people who inject drugs in planning and decision making (5).</td>
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<td>Involve community and stakeholders (5).</td>
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In response to the rising incidence of blood-borne diseases such as HIV and the growing body of evidence demonstrating the effectiveness and utility of harm reduction, Health Canada released a comprehensive position paper in 2001. The document acknowledges that IDU is a serious health and social issue in Canada with costs estimated as high as $1.4 billion per year, the majority of which are related to health care, law enforcement and lost productivity. A call was made for immediate action in harm reduction strategies to address the “immediate risk factors for people who are injecting drugs as part of a continuum of addiction interventions”, to be complemented by strategies in prevention, research, outreach, and treatment and rehabilitation (5).

In line with the conditions and principles of harm reduction, a National Framework for Action to reduce the harms associated with alcohol and other drugs in Canada was released in 2005. The framework is founded on nine principles (6):

1. Problematic substance use is a health issue and needs to be given a high profile within the health system.
2. Problematic substance use is shaped by social and other factors, including socio-economic status, culture, gender, housing, education, geography, family, law and policies, stigma, and other issues.
3. Successful responses to reduce the harms associated with alcohol and other drugs and substances address health promotion, prevention, treatment, enforcement and harm reduction approaches.
4. Action is knowledge-based, informed by evidence and evaluated for results.
5. Human rights are respected.
6. Strong partnerships are the foundation for success.
7. Responsibility, ownership and accountability are understood and agreed upon by all.
8. Those most affected are meaningfully involved.
9. Reducing the harms associated with alcohol and other drugs and substances creates healthier, safer communities.
Best Practices in Harm Reduction

Research and evaluation of harm reduction strategies have identified components essential for the reduction of HIV and other blood-borne pathogens amongst injection drug users. Examples of research and best practice are incorporated into each of the recommendations found in this section.

Best practices in harm reduction include:

**Comprehensive Services**
- Research on effective harm reduction strategies demonstrates the need for comprehensive services that include education, provision of testing services in communities and other high-risk areas (such as correctional facilities), outreach, needle exchange programs, enforcement, treatment programs and evaluation of strategies (2, 7, 8).

**Early intervention**
- Harm reduction interventions need to occur prior to an HIV prevalence rate of 10% in a population—otherwise efforts can be overwhelmed by the risks of transmission (9).
- Harm reduction strategies have been shown to be most effective when seroprevalence of HIV is low, thereby demonstrating a need for early interventions (10).

**Education**
- The World Health Organization describes information, education and communication approaches as essential components of the response to HIV infections among injection drug users (11).
- Incorporation of both individual and community education efforts through outreach services has been demonstrated to reduce drug-related risks (9).
- Stigma and discrimination against both HIV and injection drug use can be reduced through public policies that include educational activities such as: conferences; advisory councils; social marketing; individual and community education; education for professionals working with populations affected by or at risk for HIV; and advocacy efforts or campaigns (12).
- Research has demonstrated that injection drug users with less than one year of IDU experience are at high risk of blood borne infections, including HIV and Hepatitis C (13).
- Educational strategies specifically targeting injection drug users should include messages about the elimination of needle sharing or the sharing of other injection drug equipment (cookers, filters, water) as well as vein maintenance (2).
Needle Distribution and Disposal

- Research shows that needle exchange programs are not associated with an increase in drug use (14, 15) or an increase in numbers of new injectors (16). Rather, such programs have been found to encourage injection drug users to seek treatment (17, 18) and promotes contact with health services that would otherwise be absent.

- Research suggests that needle exchange programs can be gateways into treatment services for persons suffering from drug-dependency and other high-risk persons who would otherwise not direct access these services (19).

- Needle exchange programs have been shown to reduce the prevalence of HIV amongst injection drug users in 81 cities in the United States (18). This reduction has been attributed to reduced needle sharing and other harm reduction strategies such as treatment referrals, education, and condom distribution.

- Mathematical modeling of HIV infection estimates that one-third of new HIV infections are prevented with needle exchange programs (17, 20).

- Needle exchange programs have been demonstrated to be highly cost effective approaches to reducing the harm associated with IDU. Research in Hamilton, Ontario estimated that twenty-four new cases of HIV were prevented over a five-year period, resulting in savings of $1.29 million in direct health care costs (21).

Community Outreach Services

- Outreach services have been shown to be effective in changing high-risk behaviours among people who use injection drugs and thereby contribute to reducing the incidence of new cases of HIV infection. Specifically, research most frequently reports reductions in five major risk behaviours: stopping injection use, reducing frequency of injection, reducing reuse of syringes, reducing reuse of other equipment such as cookers, cotton and water, and reducing crack use (22).

- Research also demonstrates that outreach services contribute to more frequent needle disinfection, entry into drug treatment programs and increased condom use.

- Outreach services have been associated with increases in voluntary HIV counseling and testing (10).

- Outreach has been identified as a common prevention strategy that contributes to low seroprevalence of HIV in cities where HIV has entered into IDU communities (10).

- Outreach services are associated with lower rates of new HIV infection among injection drug users (22, 23).
Harm Reduction Recommendations

The following recommendations have been developed from strategic planning, relevant reports and supporting literature. Each recommendation offers specific, concrete strategies for stakeholders to consider. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies require additional support or funding for implementation. Following the presentation of strategies, a list of expected outcomes is provided. Stakeholders are encouraged to consider these outcomes as a foundation for monitoring and evaluation to incorporate in the development of action-plans.

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<th>Recommendations for Harm Reduction</th>
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Recommendation H-1
Develop a clear definition of harm reduction and incorporate philosophy into each service provider’s policy of practice.

Background
Participants at the October 2005 stakeholders’ meeting stressed that both service providers and the community needed a clear definition of harm reduction to facilitate common understanding of the concept and its implications. Stakeholders felt that the definition should be evidence-based and reflective of current practice. Furthermore, this definition should be communicated broadly to injection drug users, service providers and the community. Stakeholders desired the definition to be accepted and incorporated into each service provider's policy of practice. Finally, stakeholders agreed the definition should be consistent across all service providers and integrated into a continuum of care that is flexible to accommodate the needs of individual clients.

The Centre for Addiction and Mental Health (CAMH) provides an excellent example of a collaboratively developed, context based definition of Harm Reduction. Through a special ad hoc committee and drawing from experience and the literature, CAMH prepared a document to outline what the concept Harm Reduction meant to them as a team. Harm reduction is defined as “any policy or program designed to reduce drug-related harm without requiring the cessation of drug use” (p. 1) with interventions targeted at the individual, the family, community or society (3). This resource provides an overview of the process undertaken by CAMH to develop a common definition of Harm Reduction; reviews the historical contexts; relates Harm Reduction to treatment, prevention and enforcement; summarizes best practices; and provides a comprehensive bibliography.

Suggested strategies for this recommendation:

Short-term Strategies

1. Establish a working group under the harm reduction pillar with participants representing community, partner agencies and service providers.

2. Review the CAMH background paper, with attention to the process used to develop a common definition of Harm Reduction, and assess for its relevance to Saskatoon.

3. Create and carry out a process, adapted to meet the needs of the working group, to develop a common definition reflecting evidence-based principles of harm reduction and incorporating the group’s shared experiences.

4. Share this common definition with other members of the harm reduction pillar for validation.

5. Share the common definition with stakeholders in other pillars.
**Long-term Strategies**

1. Communicate common definition to community, service providers and partner agencies.
2. Encourage the adoption of this common definition into practice policies of service providers and partner agencies.

**Expected Outcomes**

1. A clear, concise definition of harm reduction based on evidence and reflecting stakeholders’ values is developed.
2. Definition is shared with and discussed by community partners and service providers.
3. Service providers and community partners (where applicable) incorporate the definition into their practice policies.

**Potential Lead Agency or Partner Agencies**

- Corrections Canada
- Métis Addictions Council of Saskatchewan
- Project Hope
- Saskatchewan Corrections & Public Safety
- Saskatoon Health Region—Mental Health & Addictions Services
- Saskatoon Health Region—Public Health Services (Street Health Program)
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Tribal Council
- Teen Challenge Saskatchewan
- White Buffalo Youth Lodge
Recommendation H-2
Develop an intensive education program about harm reduction that is tailored to IDUs, the community and service providers.

Background
Comprehensive educational campaigns are documented as an important component of best practices in harm reduction and have been effective in a number of Canadian cities (5, 24, 25), including Vancouver (26) and Toronto (27).

Research calls for educational interventions that range from discouraging initiation of IDU to discouraging injecting and sharing of needles amongst users. Education is required not only for injection drug users, but also for those who work with them, such as health care professionals, justice workers, social workers. Injection drug users need access to formal and informal learning opportunities about how to prevent the spread of blood-borne pathogens (28).

Stakeholders felt that it was important for communities to know that this approach is not only cost effective, but an important service to support individual injection drug users as they move through the various stages of behaviour change.

Stakeholders at the October 2005 meeting identified a need to increase community understanding of harm reduction strategies.

Several key issues have emerged from the IDU in Saskatoon: Developing a continuum of care report. The report affirms the role of community in educational advocacy and proposes the development of a multi-pronged community education campaign addressing issues in prevention, determinants of health, harm reduction and treatment/rehabilitation surrounding drug use. The report advocates for a strategy that focuses on providing balanced, accurate information to raise awareness of local resources and of the complexity of issues related to drug use. The strategy is envisioned as supportive, contributing to the reduction of stigma and mitigating shame that may be felt by communities where drug use is prevalent. Such a campaign would engage each of the four pillars.

The report identifies frontline service providers in health care and correctional facilities (as key contacts to IDU populations) and IDUs as target populations for the Harm Reduction component of this educational campaign. Enhanced education and training resources to improve their ability to provide care to IDUs in safe, supportive ways is suggested. Education directed at service providers should include strengthening awareness and understanding pathways to care; skills training on injection drugs, methamphetamines, and substance abuse; effective behaviour change strategies; and harm reduction. Education for IDU should include continuing promotion of harm reduction strategies, including safe injection practices and vein care.
Suggested strategies for this recommendation:

*Short-term Strategies*

1. Collaborate with working group under the other pillars to:
   a. Establish a team with representatives from each pillar to lead the development of a comprehensive, multi-pronged educational campaign.
   b. Review Canadian models of successful educational campaigns as components of comprehensive drug strategies.
   c. Review current media campaigns and educational programs for prevention and harm reduction around drug use and substance dependency in Saskatoon.
   d. Identify a potential model that can be adapted to meet Saskatoon's needs.

2. Advocate for the reduction of community and professional stigma about harm reduction techniques by:
   a. Communicating the shared definition of harm reduction developed under Recommendation 2.1 across the SHR, including partner agencies and community organizations.
   b. Encouraging opportunities for service providers and the community to improve their understanding of the definition and goals of harm reduction.
   c. Setting an example for other service providers and communities through stakeholder commitment to and adoption of this definition in their policies.

3. Establish a community resource and service directory clearly mapping out what services are available, where they can be found and how they can be contacted (Currently being developed by Street Health).

4. Establish regular in-services to provide staff in appropriate settings (health care, community outreach, corrections) with current information and skills training on relevant issues such as: intravenous drugs, crystal meth, substance use, and effective behavior change.

**Expected Outcomes**

1. A collaborative working team involving representatives from each of the four pillars develops an action plan for a comprehensive, multi-pronged educational campaign.

2. Stigma against IDU and harm reduction is reduced, as demonstrated through on-going evaluation of the educational campaign.

3. A community resource directory is made available to service providers and community based organization, improving communication and collaboration within and between both.
4. Relevant in-services are made available on a regular basis to health care providers and to corrections workers.

**Strategies targeting:**

1. **Healthcare workers**
   Injection drug users come in contact with the health system through drop-in clinics, emergency rooms or other services. Physicians, nurses, pharmacists, psychologists, social workers and community workers therefore require continuing education about prevention, screening, assessment and management of substance dependency and injection drug use. Additionally, on-going education on preventing the spread of infectious disease is needed, ranging from standard precautions to harm reduction practices such as methadone maintenance.

**Short-term Strategies**
1. Provide in-services on the harm reduction continuum of care to health care providers that may be providing care for IDU clients in settings outside of the Street Health Program.
2. Provide in-services on issues relevant to substance dependency and injection drug use available to health care providers on a regular basis.
3. Incorporate basic education about prevention, screening, assessment and management of substance dependency and injection drug use into required orientation sessions for new staff.

**Long-term Strategies**
1. Advocate for the incorporation of special lectures and/or curriculum content relevant to substance dependency and injection drug use into professional health education programs.
2. Lobby professional associations to recognize in-services on substance dependency and injection drug use as part of their recommended programs for continuing competency.

**Expected Outcomes**
1. Relevant in-services are made available and evaluated for appropriateness on a regular basis to health care providers.
2. Orientation sessions prepare new staff to SHR with basic knowledge and skills in prevention, screening, assessment and management of substance dependency and injection drug use.
3. Education on harm reduction and management of substance dependency and injection drug use become regular recognized components of formal education and continuing competency.
2. Corrections workers

Globally, offenders placed in correctional institutions have higher rates of HIV infection than populations outside correctional institutions and are at higher risk of exposure to HIV (and other infectious diseases) because of “…overcrowding, poor nutrition, limited access to health care, continued illicit drug use and unsafe injecting practices, unprotected sex and tattooing” (p. 3) (29). Based on evidence and recognizing the principles of public health and human rights, the World Health Organization recommends the incorporation of harm reduction strategies in prison settings. Evidence has shown comprehensive harm reduction programs, including information and communication on HIV/AIDS; voluntary testing and counseling; distribution of condoms; exchange of needles and syringes; and substitution therapy to be effective in reducing both risk behaviour associated with injection drug use and risk of exposure to blood-borne diseases (29).

Given the higher risks of exposure to blood-borne pathogens such as HIV, internal capacity to promote and provide harm reduction practices in correctional facilities is essential. Corrections workers need to be equipped with the knowledge and skills to deal with offenders who may engage in behaviors associated with a risk of exposure to blood-borne pathogens. Because corrections workers may come in contact with offenders’ blood or body fluids, they need continued training in Standard Precautions and about post-exposure prophylaxis. Education efforts can help corrections staff to understand why it is important to support harm reduction measures, such as the use of condoms for safe sex practices.

**Short-term Strategies**

1. Incorporate education and in-services about principles of harm reduction, substance dependency and injection drug use into public health services regularly offered in correctional facilities.

2. Incorporate education and in-services about Standard Precautions, post-exposure prophylaxis and risks related to blood-borne pathogens into public health services regularly offered in correctional facilities.

**Long-term Strategies**

1. Develop an interactive teaching kit or ‘train the trainer’ activity to provide corrections workers with education about IDU, risk related to blood-borne pathogens, Standard Precautions and post-exposure prophylaxis.

2. Develop an interactive teaching kit or ‘train the trainer’ activity to provide corrections workers with education about harm reduction, substance dependency and injection drug use.

3. Advocate and work collaboratively with corrections to facilitate movement towards the introduction of comprehensive harm reduction strategies, such as needle exchange and condom distribution, into correctional facilities.
Expected Outcomes

1. Relevant in-services are made available and evaluated for appropriateness on a regular basis to corrections workers.

2. Correctional workers are prepared with basic knowledge and skills in issues related to IDU, risk related to blood-borne pathogens, Standard Precautions and post-exposure prophylaxis.

3. Correctional workers develop skills to provide internal, regular training and educational support for new staff or to promote continued competency for experienced staff in issues related to IDU, risk related to blood-borne pathogens, Standard Precautions and post-exposure prophylaxis.

4. Awareness and understanding of harm reduction principles and practices improves and eventually become norms in correctional settings.

5. Correctional institutions adopt a comprehensive harm reduction strategy including practices supported by evidence and promoted by the World Health Organization.

3. Injection Drug Users

In 2005, IDUs participated in discussions to explore experiences and needs related to harm reductions. Participants felt that harm reduction and education materials need to be developed specifically for the drug using community and be culture and language appropriate.

A number of organizations in Canada have developed resources that could be adapted with permission for use in Saskatoon. These include:


- Pamphlets and educational materials for IDUs: Community AIDS Treatment Information Exchange (CATIE) (Toronto); the Centre for Addiction and Mental Health (CAMH) (Toronto); and the Harm Reduction Coalition (New York).

Short-term Strategies

1. Contribute to raising awareness among IDUs about how to reduce risks to themselves and others (users or not) by providing support and education around resisting the pressures to share needles. Education can be provided through the Health Works van and at fixed needle exchange sites.

2. Develop a working group to review current printed educational materials, including those presented above and those currently in use within the SHR and select those that are most relevant to Saskatoon.
3. Hold focus groups with IDUs/community members to review selected materials and receive feedback on:
   a. How materials might be best adapted to meet their needs.
   b. What material/content is missing.
   c. Where materials should be available.
4. Develop/adapt printed materials based on feedback received.

**Long-term Strategies**
1. Print new materials and distribute through service providers, community organizations and other locations identified by the focus groups.

**Expected Outcomes**
1. Printed educational materials are reviewed, adapted with participation of IDUs and community members and made available in appropriate, accessible locations.

**Potential Lead Agency or Partner Agencies**
- AIDS Saskatoon
- Corrections Canada
- IDU-user groups
- Persons Living with AIDS (PLWA)
- Saskatchewan Corrections & Public Safety
- Saskatoon Health Region—Public Health Services
- Saskatoon Health Region—St. Paul’s Hospital, Royal University Hospital, and City Hospital
- Saskatoon Tribal Council
Recommendation H-3
Expand outreach services through existing organizations.

Background
Outreach services are one way of reaching client groups who may be reluctant to access traditional services for a variety of social, economic and geographic reasons (30). Outreach involves providing information, support and facilitating access to or connecting with other agencies or services and can be provided on the street, in client homes or in other settings such as prisons, shelters and community agencies (30). These services are integral to harm reduction and have been shown to be effective in reaching IDUs and reducing risk-taking behaviour and HIV incidence (2, 22). Effective outreach programs often involve peers or are peer-led and typically run in conjunction with needle exchange programs (2).

Needle exchange programs are often part of outreach services and have been shown to effectively reduce the spread of HIV (18, 31) and other blood-borne diseases (19, 21). Interventions combining youth-centred, service-based care with street outreach, case management and collaboration with other services have been shown as beneficial approaches to meeting the healthcare needs of homeless youth (32). A recent comprehensive review of international literature called for the inclusion of needle exchange programs as an effective foundation for the establishment or expansion of such programs (33).

The Street Health Program has been offered through the Saskatoon Health Region since 1990 (34). The program aims to “maintain or reduce the prevalence of blood-borne pathogens (HIV, Hepatitis B & C), sexually transmitted infections and their health, social and economic consequences in Street Health clients which include inmates, street-involved individuals, sex trade workers and IDUs in Saskatoon” (p. 2) (35). These services are provided through the mobile outreach service, the Health Works van, the Sexual Health Clinic and corrections. Services provided in the Health Works van include: immunization for pneumonia, Hepatitis A and B, tetanus, and influenza; urine testing for Chlamydia, gonorrhea and pregnancy; blood screening for HIV, Hepatitis B and C, and syphilis; clean needles in exchange for used needles; distribution of biohazard containers, condoms and lubricant; provision of first aid; education on safer sex and IDU practices; counseling, crisis intervention and referral; and advocacy on behalf of clients for social issues (e.g. legal issues, housing, connecting to methadone clinic) (35). The Westside Community Clinic also provides a small volume of needle exchange services and acts as the exchange site of “last resort”, only issuing a small quantity of needles until clients can reconnect with the Health Works van.

Through focus groups conducted with persons using injection drugs (as part of the At Risk project), IDUs in Saskatoon felt they did not have enough access to clean needles and recommended 24 hour access to needle exchange services.
as well as the expansion of fixed exchange sites to include doctors’ offices and pharmacies. Some participants felt that it was difficult to get clean needles at night and suggested a syringe dispenser to dispose of used ones and get clean ones (36).

The SHR-MHO Report of April 2006 (Investigation of an HIV Cluster among Injection Drug Users (IDUs) in Saskatoon, Saskatchewan) provides a number of specific recommendations for the expansion of harm reduction interventions aimed at reducing incidence of HIV. Furthermore, the report acknowledges the need for greater human resources in the Street Health Program and recommends improved recognition of the demands of working with IDU populations through the provision of greater workload flexibility.

The following recommendations are to be considered in conjunction with Recommendation H-4 (Community-based Harm Reduction).

**Strategies for this recommendation:**

**Short Term Strategies**

1. Expand outreach services through existing organizations (e.g. Street Health, Addictions) to provide greater accessibility to services and access to IDUs and their families and build supports for outreach workers to advocate for clients and enable them to provide more comprehensive care. Strategies for building these supports include adapting organizational policies (including budget/salary support) and job descriptions for outreach workers and nurses so that they, or their programs, can:
   a. Accompany clients to/from appointments.
   b. Connect with clients in their community to provide services, such as immunization, and education in supportive, comfortable environments.
   c. Facilitate or coordinate appropriate volunteers to help clients get to appointments.
   d. Establish greater coverage and expand service of mobile services (i.e. Health Works) in communities with identified needs.
   e. Intensify efforts in HIV surveillance with daytime community visits.
   f. Dedicate one FTE-public health nurse position to HIV contact tracing.
   g. Collaborate with other program areas to ensure immunizations, testing and Hepatitis C and HIV co-infections are addressed.
   h. Support clients who are waiting for test results and who receive HIV-positive results.
2. Adapt strategies used in *Health Works* outreach services to strive for data base registration of 100% of clients to facilitate better interaction with other programs and more responsive care (e.g. hepatitis B and A immunization).

3. Consider Needle Safe Saskatoon Annual Report and data from the Street Health Database in making decisions about changes to scheduled *Health Works* van stops.

4. Incorporate teaching about the HIV-related risks involved in sharing and preparing drugs for injection during needle exchange visits and other *Health Works* visits.

5. Offer adequate injection supplies to cover clients’ usage needs until the next available service from either the *Health Works* van or an accessible fixed needle exchange site.

6. Expand the number of settings providing condoms, including service providers (Infectious Disease Clinic, doctors’ offices, clinics, drug and alcohol treatment programs and all healthcare facilities); community-based organizations (EGADZ, Friendship Inn, others); social settings (bars, clubs, bathhouses and commercial sex avenues); schools; and correctional facilities.

7. Consult with staff involved in outreach programs to:
   - Assess their feelings around work-related stress.
   - Develop a strategy for recognizing the demands of working with IDU populations.
   - Collaboratively develop a plan to promote flexibility in workload, emphasizing the value of experienced staff and promoting staff retention.

**Long Term Strategies**

1. Consider incorporating client incentives (nutritional or financial) to facilitate follow-up with difficult-to-reach cases and contact.

2. Expand outreach services to include prevention activities, including the identification of at-risk youth and the provision of supportive services to prevent these youth from engaging in IDU.

3. Advocate for the introduction of needle exchange services as part of comprehensive harm reduction programming in correctional facilities, building upon Recommendation H-2 (Comprehensive Educational Campaign).

4. Conduct annual needs evaluation engaging members of the IDU community to ensure that outreach services are responsive to the dynamic needs of communities in which services are provided.

5. Establish new fixed needle exchange sites in response to needs identified by IDUs.
6. Increase *Health Works* outreach services to provide needle exchange and testing services on Saturdays, Sundays and Mondays.

7. Expand case management approaches to facilitate regular client follow-up with the *Health Works* van.

8. In conjunction with the Treatment & Recovery working group, consider establishing a clinic site where clients can access multiple services from one centralized and easily accessible location. Such services might include needle exchange, condom distribution, testing and counseling for HIV and other blood-borne pathogens or sexually transmitted infections, mental health and addictions counseling, methadone assisted recovery, spiritual and cultural care, and social services or other community supports (See Recommendation T-2).

**Expected Outcomes**

1. Needs evaluation demonstrates that IDUs identify and access more services, including daytime outreach services and referrals to other service areas.

2. Outreach services expand programming to include prevention strategies.

3. Outreach workers regularly engage in collaborative determination of what supports clients may need.

4. Evaluation using the Street Health database shows that the number of *Health Works* interactions with individuals registered in the database increases.


6. Epidemiologic surveillance of the incidence of new blood-borne diseases among clients registered with the Street Health database decreases over time.

7. Staff evaluations demonstrate outreach service providers feel fulfilled with their work and are satisfied with workload.

8. Staff retention in outreach services improves.
Potential Lead Agency or Partner Agencies

- AIDS Saskatoon
- Corrections Canada
- EGADZ Youth Centre
- Methadone Assisted Recovery Programs & Certified Physicians
- Métis Addictions Council of Saskatchewan
- Project Hope
- Saskatchewan Corrections & Public Safety
- Saskatoon City Police
- Saskatoon Health Region—Mental Health & Addictions Services
- Saskatoon Health Region—Public Health Services
- Saskatoon Health Region—Infectious Disease Control
- Saskatoon Tribal Council
**Recommendation H-4**
Advocate for increased community-based actors to increase access to harm reduction services.

**Background**
Studies exploring best practices in outreach services identify community-based access to harm reduction services as essential for reaching IDUs because they are often not in contact or do not feel supported or welcomed by mainstream health services (37-39). Creative approaches to outreach services have been employed in cities around the world. In Britain, for example, ex-users were recruited as outreach workers to provide education and referrals as well as distribute condoms and needles. The approach was found to be highly successful because the outreach workers were accepted by at-risk populations and were able to provide effective education and harm reduction services (40).

Further support for enhancing community-based access to harm reduction services is found in the Addley report (41). The report recommends the establishment of a new, flexible and community based provincial treatment model. The report calls for the expansion of outpatient and outreach services, particularly for youth, and suggests increasing the hours of operation for street-front, community based centres to include evenings and weekends. These community-based centres are envisioned as comprehensive and multi-disciplinary, offering clinical services, parenting education, counseling, crisis intervention and other social services.

A number of community youth programs aiming to reduce harm among IDUs and prevent IDU in high-risk persons are available in Saskatoon, including (among others) *AIDS Saskatoon, EGADZ, My Home, and Youth Circles*. As community-based access to harm reduction is expanded, efforts need to be made to ensure that services and strategies are flexible, culturally acceptable, accessible, age and gender appropriate, user-friendly, staffed by appropriate outreach personnel, and involve IDUs in the design, implementation and evaluation of programs (36).

Stakeholders at the October 2005 meeting felt that advocacy was need to increase community-based access to harm reduction services (including HIV testing, needle exchange programs, information, direct services to IDU clients). The development of multiple, accessible sites within existing programs/organizations was suggested as one way to improve community-based services in harm reduction.

The following recommendations are to be considered in conjunction with Recommendation H-3 (Expansion of Outreach Services).
Strategies for this recommendation:

**Short Term Strategies**
In addition to those strategies suggested under Recommendations H-3 (Expand Outreach Services) and H-5 (Continue Needle Safe):

1. Facilitate opportunities for community development through community kitchens, peer groups or workshops on HIV prevention.

2. Collaborate with local food banks and food security programs to provide a non-perishable food item to clients seen in the Health Works van.

3. Consult with community members (for example, through focus groups) to brainstorm activities or services for which they would feel supported by peer-leaders.

**Long Term Strategies**

1. Expand needle exchange hours to provide service either (a) during more hours of the night or (b) 24 hours to respond to identified community needs.

2. Incorporate peer-leaders into harm reduction strategies through community development, volunteer programs or others.

3. Collaborate with existing multi-service centres, such as SWITCH (Student Wellness Initiative Towards Community Health) and other primary care clinics, to provide evening and weekend outreach services to youth that include clinical services, parenting education, counseling, crisis intervention and other social services.

**Expected Outcomes**

1. IDUs identify and participate in more opportunities for community development, mentoring and peer support through, for example, collective kitchens and HIV prevention workshops.

2. Follow-up evaluation shows that services are provided closer to communities that need them.

3. Collaborative efforts are undertaken to provide multiple services in locations that are welcoming, accepting and comfortable for community members.
Potential Lead Agency or Partner Agencies

- AIDS Saskatoon
- CHEP
- IDU-user groups
- Persons Living with AIDS (PLWA)
- Station 20 West
- SWITCH
- West Side Community Clinic
**Recommendation H-5**  
Continue Needle Safe Saskatoon partnership.

**Background**  
A community-based, collaborative needle disposal program was first piloted in Baltimore, Maryland under “Project Red Box” as an effort to improve public safety by reducing community exposure to used needles. The project evaluation showed promising results: fewer needles were found on the streets, people were satisfied that the project was resulting in fewer discarded needles in their neighborhoods, and collaboration between police and public health was enhanced (42). The program was expanded and has served as a model for other community-based needle disposal programs.

Community-based needle disposal and clean-up programs have expanded, developing into coalitions engaging local and national organizations, businesses, government, pharmaceutical associations, diabetes associations and HIV/AIDS associations in New York (43) and, more broadly, in the United States (44) and partnerships between local health departments and communities (45). In Canada, a syringe recovery program was integrated into both Vancouver (46) and Toronto’s (27) comprehensive four-pillar drug strategies. As part of the Safedmonton strategy, safe needle disposal toolkits including disposal containers, posters, presentations and information on safe needle box locations and collection statistics have been developed for schools and community groups (47).

*Needle Safe Saskatoon*, established in 1999, offers a variety of harm reduction services, including needle recovery by collaborating agencies, a Street Patrol Project (April-October) to recover used needles in the community, strategically placed needle drop boxes, provision of landlord kits for safe needle disposal and a media campaign. The program is a successful collaborative venture between PHS, Saskatoon Fire and Protective Services, City Police and other community agencies. The community-based education campaign has successfully contributed to creating community support for needle drop boxes (48). Stakeholders at the October 2005 meeting felt that the *Needle Safe Saskatoon* program should be continued as an effective harm reduction strategy for both IDUs and the public.

**Strategies for this Recommendation:**  
**Short Term Strategies**
1. Expand or maintain needle drop box coverage to include public locations most frequently reporting street needles in Saskatoon (According to *Needle Safe Saskatoon* Annual Reports).
2. Encourage 1:1 needle exchange in the *Health Works* van and at fixed needle exchange sites.
3. Enhance efforts to minimize needles discarded by IDU clients registered with the Street Health Program by increasing client teaching about needle exchange services to:
   - Emphasize that biohazard containers distributed must be returned for exchange through Health Works or at fixed sites.
   - Ensure that clients receive sufficient biohazard containers for both the needles exchanged and for needles anticipated in their homes.

4. Continue distributing “Needle Safety at Work” videos with kits.

5. Expand safe needle disposal toolkit program to include schools and community groups, drawing from available examples as models (e.g. Safedmonton).

6. Continue peer-led needle recovery program and consider incorporating activities with those suggested under Recommendation 2.4 (Expand Community-based Access).

7. Consider contribution of Saskatoon’s Needle Safe program to best practices literature through:
   - Publication of experiences.
   - And incorporation of research, potentially with collaboration with the relevant departments at the University of Saskatchewan (including potential linkages with graduate students).

**Long Term Strategies**

1. Collaborate with local pharmacies to provide biohazard containers and teaching about safe disposal when distributing medical needles.

2. Conduct regular self-evaluations of peer-led needle recovery program to examine goals and challenges and identify future directions.

3. Advocate for expansion of safe needle disposal options to rural settings.

4. Advocate for environmentally sound disposal of biohazardous materials collected through Needle Safe.

**Expected Outcomes**

1. Needle Safe continues, demonstrating expanded and strengthened services in annual reports.

2. Evaluation using the Street Health database shows that the number of Health Works interactions listing ‘needle disposal/exchange-counseling’ and ‘Street Health program overview’ as services provided increases.

3. Evaluation using the Street Health database shows that the number of Health Works clients with exchange rates of 100% increases.
4. Needle Analysis Annual Reports show a decline in the number of needle-stick injuries reported, particularly in public locations.

5. Collaboration with other key actors, including correctional facilities and pharmacies, is demonstrated through expanded services, teaching and a reduction in the number of loose medical needles returned through needle drop boxes.

6. Regular self-evaluations of peer-led needle recovery program are conducted.

Potential Lead Agency or Partner Agencies
- City of Saskatoon
- Riversdale Business Improvement District
- Saskatoon & District Chamber of Commerce
- Saskatoon City Police
- Saskatoon Fire & Protective Services
- Saskatoon Health Region—Public Health Services
- Saskatoon Needle Safe Partnership
**Recommendation H-6**
Expand harm reduction strategies beyond needle exchange to include the provision of a full range of drug and equipment and supplies for other drugs.

**Background**
In Canada, injection drug use is the most common mode of transmission of Hepatitis C virus (HCV) with an estimated 90% of IDUs becoming infected within 5 years of injection drug use (49). The prevalence of HCV infection among injection drug users has been reported at 30-98% (50). Studies demonstrate a significantly increased risk of HCV for IDUs sharing injection drug equipment, even when sterile needles are used (51, 52). Research in Halifax, Nova Scotia demonstrated a low level of awareness of the risks of sharing equipment, such as water and spoons, among drug-using populations (53). The effectiveness of HCV risk reduction through needle exchange alone is questioned by findings from another large-scale study conducted in Seattle (54). Each of these studies call for the incorporation of greater efforts to education IDUs about the risks of sharing equipment and several recommend the inclusion of paraphernalia (cookers, spoons, sterile water and cotton filters) into needle exchange programs.

In Canada, several needle exchange programs have successfully integrated the provision of comprehensive supplies including filters, water, tourniquets, and cookers into their exchange services. Examples of programs including such supplies into needle exchange programs are Regina, Vancouver and Toronto.

The 2006 Medical Health Officer’s report, *Investigation of an HIV Cluster among Injection Drug Users in Saskatoon*, recommended the expansion of harm reduction strategies beyond needle exchange to include additional supplies including filters, water, and spoons (cookers). Furthermore, participants at the October 2005 Stakeholders’ meeting identified a need for services in equipment exchange other than needles (e.g. pipe exchange for crystal meth).

**Strategies for this recommendation:**

**Short Term Strategies**
1. Communicate with other needle exchange programs distributing injection drug equipment (cookers, cotton and water) to:
   a. Explore options available.
   b. Examine costs and benefits of different options.
   c. Learn from feedback, comments and experiences.
2. Prepare a plan and budget proposal for the incorporation of other injection drug equipment (cookers, cotton and water).
3. Continue to focus teaching opportunities in outreach services on the risks involved in sharing *any* drug paraphernalia.
4. Continue to focus teaching opportunities in outreach services on safe injection practices, including the use of filters (cotton).

5. Evaluate currently available educational materials on safe injecting practices.

**Long Term Strategies**

1. Expand Needle Safe to include the provision of other injection drug equipment such as cookers, cotton and water.

**Expected Outcomes**

1. Additional injection drug equipment is made available to clients accessing needle exchange services.


**Potential Lead Agency or Partner Agencies**

- IDU-User groups

- Saskatoon Health Region—Public Health Services (Street Health)
Recommendation H-7
Pending successful evaluation of Insite (Canada’s first supervised injection site) and federal approval for expansion of similar programs, consider a supervised injection site for Saskatoon.

Background
Evaluations of safe-injection facilities indicate that such facilities contribute to improved health and social function of clients; reduced deaths related to overdose; reduced HIV risk-related behaviours, public drug use, and unsafe disposal of syringes (55). A cross-sectional study conducted in Vancouver showed the need for collaboration and cooperation with police prior to the introduction of their first pilot of a safer injection site (55).

North America’s first supervised safer injection site was opened in Vancouver in September of 2003. The federal government approved the project as a three-year pilot, on the condition that on-going, rigorous scientific evaluation is incorporated into program planning (56). At this facility, clients are provided with clean injecting equipment, medical attention in the case of overdose and access or referral to primary health care and other services such as addiction treatment. Evaluation of this site demonstrates “substantial reduction in the starting of binge drug use” (p. 221) and reductions in syringe sharing among local injecting drug users (57). Reductions in public drug use, publicly discarded syringes and injection-related litter have also been found (58). The site has also been found to prevent some acute drug use complications, such as overdose and inflammation or abscesses in injection sites (56).

Stakeholders at the October 2005 meeting felt that, following extensive research and community consultation and education, supervised injection sites should be considered for Saskatoon. This may become a particularly important recommendation for consideration if evaluation of the Saskatoon Injection Drug Use Strategy demonstrates persistent unmet needs for IDUs.

Strategies for this recommendation:
Short-term Strategies
1. Consult with community members and other stakeholders to:
   a. Discuss the potential strengths and challenges of offering safe injection sites in Saskatoon.
   b. Consult with stakeholders from Vancouver’s safer injection site to learn from their model and explore the potential for implementation in other Canadian cities.
   c. Discuss potential locations that meet the community’s needs.
   d. Develop a proposal for the introduction of a pilot safe injection site in Saskatoon, with built-in, on-going evaluation and research that includes baseline and community responses.
   e. Secure funding for implementation of the pilot program.
f. In conjunction with Recommendation H-2 (Develop an intensive education program), develop a strategy for an active community awareness campaign that aims to create greater support and understanding for IDUs in the city of Saskatoon through providing education on: harm reduction, determinants of health contributing to substance abuse and the benefits of safer injection sites experienced by other communities (e.g. Vancouver).

**Long-term Strategies**

1. Conduct baseline evaluation of community needs around safer injection sites in Saskatoon.
2. Implement community awareness campaign.
3. Implement a pilot safer injection site in Saskatoon with built-in, on-going evaluation.
4. Respond to evaluation of pilot program for safer injection sites, expanding services and locations where appropriate and adjusting to community needs.

**Expected Outcomes**

1. Pilot program for safer injection site is initiated with the support of both the IDU community and the community as a whole.
2. On-going evaluation shows that community awareness and understanding of the role of safer injection sites in harm reduction and of determinants of health influencing substance abuse improves.
3. On-going evaluation is responded to with appropriate expansion of services to meet community needs.
4. Research evaluating the safer injection site is published in peer-reviewed journals.

**Potential Lead Agency or Partner Agencies**

- Saskatchewan Health
- Saskatoon Health Region—Public Health Services
- University of Saskatchewan
References


(3) Centre for Addiction & Mental Health. CAMH and Harm Reduction: A background paper on its meaning and applications for substance abuse. Toronto, ON: Centre for Addiction and Mental Health; 2002.


Part 6: Enforcement

Introduction
This pillar addresses issues related to illegal drugs and their control. Enforcement “…addresses the need for peace, public order, and safety in our homes, local neighborhoods and the whole city…” (p. 36) (1) and encompasses interventions seeking to strengthen public safety and to respond to criminal offenses and activities that threaten community stability or safety (2). These offenses and activities may include (3):

- Possession of illicit drugs.
- Importation, distribution or production of illicit drugs.
- Selling or trafficking of illicit drugs.
- Prescription shopping.
- Drug-related crime.

Several Canadian drug strategies (2, 4, 5) include recommendations for enforcement, each of which reflect diversity in underlying values, beliefs and perspectives. Common to each, however, is a call for collaboration between health, education and enforcement sectors as part of the development of responsive, integrated drug strategies.

There are a number of key players, including governments and the criminal justice system (courts, judges, police, and correctional centres), who contribute to enforcement responses to illicit drug use. Many enforcement policies and decisions are federally-driven; however, attorneys, lawyers, police, public health organizations, communities and, importantly, IDUs all have an interest in how enforcement policies are structured and how they are carried out. Not unlike the diverse values and perspectives underlying different drug strategies, the actors involved in policy development and implementation in enforcement are not always the same.

Stakeholders working in this pillar must therefore work to develop collaborative responses to these recommendations that acknowledge and balance the different values of individuals and groups involved. Each of these actors plays an important role in enforcement and needs to be engaged in planning for change. The response to these recommendations should acknowledge the needs of injection drug users (IDUs) and of the community as a whole while balancing the values, flexibilities and limitations of those involved in the enforcement of drug related laws.
Best Practices in Enforcement

There is little research and literature around ‘best practices’ in the enforcement of drug-related laws. Rather, views and practices found in the literature represent a high degree of debate around what policies in drug control and enforcement are the most effective and responsive to the needs of local, national, and global communities. Positions on local enforcement issues for IDUs range from ‘zero tolerance’\(^1\) to calls for decriminalization of the possession of drugs for personal use.

Current International, National and Local Policies

International agreements on the enforcement of drug laws are important to consider in the examination of best practices because they are the foundation for the development of drug laws and strategies for many countries, including Canada, and are powerful political statements.

Internationally, regulations addressing illicit drugs are outlined in three main documents, made available by the United Nations Office on Drugs and Crime (6):

- Convention on Psychotropic Substances (1971)
- UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988)

The 1988 Convention re-affirmed and expanded the UN position relative to the global drug crisis (7), providing a foundation for the global development of drug laws and enforcement policies that criminalize the possession, sale, distribution, production, and importation/exportation of specific substances (6). Because the convention promotes the criminalization of the production, supply and use of drugs in the domestic law of member States, it is considered a prohibitionist policy (8).

Two key documents outline current regulations for illicit drug control, supply reduction and enforcement in Canada. These include the 1996 Controlled Drugs and Substances Act (CDSA) (9) and the CDSA (Police Enforcement) Regulations (1997) (10). The CDSA details both what substances are controlled and what constitutes an indictable offence under the Act (9). Broadly, the CDSA states that no person shall seek, obtain, traffic, import, or produce a controlled substance. People who commit any one (or more) of these offences are considered liable to either a fine or imprisonment, depending upon the nature of the offence. This means that asking for, buying or possessing a controlled

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\(^1\) Zero tolerance is a term used to describe “…a non-discretionary enforcement policy for the criminal law or informal rules…”, such as the approach used for individuals charged with driving under the influence of alcohol. This approach restricts flexibility in favor of applying a pre-determined punishment for a particular offense, regardless of individual culpability (From: Wikipedia (2006). Zero Tolerance. [Electronic source on the Internet; Last updated 23 December 2006]. Available at: http://en.wikipedia.org/wiki/Zero_tolerance)
substance for non-medical purposes, or without a prescription, is considered a criminal offence. The substances controlled under this act include all derivatives, salts, analogues, alkaloids and/or preparations of opium poppy, coca, cannabis, amphetamines, and barbiturates (Refer to Schedules I-IV for details) (9).

Saskatoon’s police enforcement efforts are led by the Saskatoon Integrated Drug Unit (SIDU). The SIDU tries to reduce the amount of illicit drugs found on ‘the street’ and addresses drug-related criminal offences. According to SIDU, best practices in enforcement are dependant upon local needs and contexts and must reflect the law as it is written (11). SIDU therefore supports a ‘zero-tolerance’ approach to enforcement. As such, SIDU considers the enforcement of regulations and laws related to illicit drugs as the only acceptable boundaries and standards for best practice. SIDU calls for improved collaboration between public health, treatment and enforcement in Saskatoon and suggests that the crisis created by an arrest for a drug related offence can be used as a point-of-entry into supportive, rehabilitative care and treatment for drug addictions. SIDU further highlights the need for integrative approaches that involve judicial, correctional and enforcement branches with bridges to both health and education.

**Health and Enforcement in Partnership (HEP)**
Health Canada provides a report and resource guide to promote collaborative policy planning by police, justice, community groups, and health and social agencies. The report was developed by a HEP steering committee made up of a wide range of institutional and organizational representatives to build healthier, safer neighborhoods throughout Canada (12). The report reviewed existing drug-related risk, demand and supply reduction, and diversion (using discretion to warn rather than charge drug users who are caught) projects from across Canada that were considered to be examples of HEP. The shared goal of these examples of HEP projects is to improve health and public safety for both vulnerable groups and communities at large.

A number of key strengths found in successful HEP projects are offered. Police support, particularly from those who are committed to community policing approaches to law enforcement, was reported to be a critical component of successful HEP projects (12). Community policing is described as a response to an increasing “tendency to see police work as a public service to which the public has a right (and perhaps an obligation) to influence…” (p. 13). Additionally, fiscal restraints, health and social factors (such as HIV, HCV, and tuberculosis), recognition of the limitations of enforcement, and legislative reforms are named as reasons for adopting collaborative partnerships between health and enforcement.
The report draws from the experiences of successful HEP examples to provide recommendations for building effective collaboration. Collaborative HEP projects are encouraged to (12):

- Negotiate mutual expectations and rules concerning confidentiality and accountability.
- Ensure representation from a wide cross-section of agencies, service providers and service clients.
- Identify community resources and training needs.
- Clearly identify particular problems and target groups for any given actions taken.
- Allow flexibility in the options for action while maintaining clear foundational guidelines.
- Ensure that officers working at street level are part of collaborative project and are involved in decision-making.
- Adapt police staff evaluations to reflect community-policing and problem-solving requirements.

The Enforcement & Illegal Drugs Debate
There is much debate around the effectiveness and appropriateness of both the Canadian and International regulations of controlled drugs and substances. The polarization of viewpoints in what drug laws and regulations should be and how they should be enforced draws further attention to the need for careful, in-depth consideration of the values, beliefs and needs of stakeholders engaged in the enforcement pillar. Although Saskatoon’s integrated drug strategy will not resolve this debate, the differing perspectives are important considerations in the pillar development and future advocacy actions. Given the lack of literature exploring best practices in enforcement, this debate and the enforcement pillar’s response to these recommendations offer important opportunities to contribute to the creation of evidence-based best practices in enforcement.

Background to the ‘War on Drugs’
In the 1980s, under rapid de-industrialization and the sudden loss of labour-related jobs, unemployment among youth and unskilled or semi-skilled labourers rose dramatically in North America and the United Kingdom. The result was a large, unemployed youth with few options. This structural change in the job market and economy was considered to be an important factor contributing to a sudden, wide-spread increase in drug use during this time (13).

In response to the growing epidemic of drug use, the United States and the United Kingdom joined independent efforts to “wage war on drugs” (p.411) (13). The launch of United States’ ‘War on Drugs’ and ‘Just Say No’ to drugs campaign, first under President Nixon and later under President Ronald Reagan, coincided with a British campaign based on the slogan, ‘Heroin Screws You Up’
The War on Drugs has been criticized for failing to acknowledge social and structural factors contributing to increased drug use and for failing to reduce the use of illegal drugs; yet it continues to absorb billions of dollars in national budgets every year (13).

Although the United States continues to push for a zero-tolerance approach and the continuation of the ‘War on Drugs’, several countries, including Australia and the Netherlands, have increasingly exercised the interpretive room allowed within the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances by adapting their drug laws and policies to fit within a harm-reduction model or to reflect pragmatic approaches to the complexities of IDU (6).

What’s going on in Canada?
Within Canada, perspectives on enforcement issues in IDU are also diverse. Public health approaches tend to focus on recent changes in the patterns of HIV/AIDS among people who use injection drugs and support policies that would decriminalize the possession of small amounts of controlled substances for personal use and promote greater efforts in integrated harm reduction, prevention and treatment. Police perspectives vary across the country, but are restricted because their role is to enforce the laws and policies as they are written (11, 12).

Like other critics of prohibition and the ‘War on Drugs’ (8), some Canadian drug strategies argue that prohibition has negative consequences for both IDUs and communities. The Toronto drug policy program highlights the inability to control the quality or potency of illegal drugs as an unintended consequence of prohibition (2). The Vancouver drug policy program criticizes the current stance of the UN and its reflection in Canadian law, stating that prohibition policies “…restrict governments’ ability to intervene, influence, or regulate the production, sale and consumption of these substances…” (p. 52) (4). The program calls for “the reduction of policy-related harm through the creation of public health-centred and evidence-based legal responses to psychoactive substances” (p. 52).

Further criticisms of the current model of drug law and enforcement argue that, despite an overwhelming body of evidence of its failure, the persistence of prohibition is the result of historical, moral and political influences that demonize drug use and promote the false belief that the global elimination of drugs is possible (8). The failure of the 1920s alcohol prohibition in the United States is often provided as an example for how the prohibition of a substance with high market demands led to crime, violence, disorder and public harm (8, 14).
According arguments against prohibition, the *harms* caused by policies that criminalize drug use include (4, 8):

1. The creation of different types of crime, such as:
   - Internationally and locally organized criminal gangs.
   - Money-raising crime carried out by low-income dependant drug users.
   - Street sex workers, created by both female and male low-income dependant drug users.
   - Prohibition crimes associated with the production, supply and possession of drugs.
   - Corruption.

2. The contribution to a growing crisis in the criminal justice system and prisons through high incarceration rates and the social and economic costs of the conviction of non-problematic drug users.

3. The generation of excessive costs of enforcement and lost tax revenues in favour of criminal profits.

4. The undermining public health and maximizing harm by facilitating the circulation of illegal drugs with unknown strength and purity or possible contamination.

5. The destabilization of producer countries, such as Colombia, through the undermining of social, economic and political stability.

6. The social marginalization of people who use drugs through the undermining of human rights. Under prohibition, drug users (whether their drug use is problematic or not) are labeled as criminals and experience obstacles in achieving employment, securing housing and financial stability as well as other limitations to achieving a healthy and productive life.

As stakeholders working in this pillar consider the recommendations provided below, the debate surrounding what constitutes effective enforcement policies for controlled drugs and substances will undoubtedly surface. It is important to consider that there is no one, universally agreed-upon position and that the response to these recommendations must be based on an integration of the experience and expertise of stakeholders involved as well as careful consideration of available research and resources.
Enforcement Recommendations

The following recommendations have been developed from strategic planning, relevant reports and supporting literature. Each recommendation offers specific, concrete strategies for stakeholders to consider. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies require additional support or funding for implementation. Following the presentation of strategies, a list of expected outcomes is provided. These outcomes provide a foundation for monitoring and evaluation that stakeholders are encouraged to incorporate when developing their plans of action.

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**Recommendation E-1**
Adopt a holistic approach that recognizes the social determinants underlying addictions and drug-related crime.

**Background**
Social determinants of health include the different social, cultural, economic and structural aspects of our lives that contribute to our health through creating or restricting the opportunities and options available to us. They include social or structural aspects of life that influence our health and well-being, such as: education; employment and income; sense of community; social stigma and marginalization; access to health and social resources; early childhood development; culture; genetics and biological endowment; public policy; working conditions; physical environments; personal coping skills; safety and security; among others (15-17). Although there is much research on enforcement, IDU and drug-related crime (See, for example: (18-23)), there is notably less research exploring the socio-economic determinants of health that contribute to IDU.

Despite this gap in available research, the World Health Organization argues that “…alcohol and drug use need to be seen as multidimensional and complex behaviours which cannot be simply said to be the result of ‘free choice’—they often occur in the context of difficult social, environmental and economic conditions, in which the ‘freedom’ to choose to take or not take a substance is seriously jeopardized and driven by several other individual and environmental factors…” (p. 99) (24).

There is general agreement that social determinants of health significantly contribute to IDU and its consequences. Disadvantages in social determinants of health have been shown to both contribute to and be created by IDU (25). Social marginalization, for example, can lead to IDU and IDU can lead to greater social marginalization—creating a vicious circle that further limits the options and opportunities available to IDUs (13, 26). In a systematic review of research on of drug use and misuse, adverse family conditions (particularly during childhood), socioeconomic status, neighborhood deprivation, and family and social network norms were found to be the most commonly reported social determinants contributing to illicit drug use initiation and maintenance (27).

A recent Canadian study compared social, health and drug use characteristics of illicit opioid use in Canada (28). The study includes five sites from across the country and included 679 participants who were interviewed to provide baseline data and continue to participate in follow-up studies. The study demonstrates high rates of HIV and HCV, physical and mental health problems, homelessness, sources of semi-legal or illegal income, and exposure to the criminal justice system. The authors characterize the cohort as socially marginalized and highlight their exposure to high-risk environments associated with negative health outcomes (28).
Given the complexity of the social determinants of health contributing to IDU and any potential negative consequences for both individuals and communities, including drug-related crime, it is critical that enforcement policies adopt holistic approaches that acknowledge the diverse conditions that create vulnerability to outcomes such as drug-related crime.

Evaluating the potential health impacts of any such policies is similarly complex. The Public Health Agency of Canada suggests that policies, health outcomes and health determinants are mutually influential (29). They recommend using Health Impact Assessment as a tool for population health promotion and public policy development. Details of the strategies suggested for conducting Health Impact Assessment can be found on the website of the Public Health Agency of Canada\(^2\).

Stakeholders at the October 2005 and October 2006 meetings identified the need for enforcement efforts to help ‘break the cycle’ of IDU. Both Toronto and Vancouver support drug strategies that acknowledge multiple social determinants of health (2, 4).

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Establish a working group under the enforcement pillar with participants representing community, partner agencies and service providers.
2. Review the articles presented in the background for this section (24, 27, 28), with attention to the diversity of the social determinants of health that contribute to IDU and drug-related crime.
3. Collaboratively establish a mission statement for the enforcement pillar acknowledging the complex social determinants of health that play a role in IDU and drug-related crime. This statement will act as a guide for future actions of the working group.
4. Consider adopting a policy evaluation tool, such as the health impact assessment technique described above, that examines the potential positive or negative impacts of a particular change on a variety of social determinants of health.
5. Share this mission statement with other members of the enforcement pillar for validation.
6. Share the mission statement with stakeholders in other pillars.

**Long-term Strategies**

1. Communicate the mission statement to community, service providers and partner agencies as a tool for political advocacy and education for the reduction of stigma against IDU and its contribution to increasing social marginalization.

2. Encourage the adoption of the mission statement into practice policies of service providers and partner agencies.

3. Consider incorporating an exploration of the social determinants of health influencing IDU and drug-related crime, potentially through the use of *Health Impact Assessment*, into any program of research supported by the enforcement pillar.

4. Consider the potential contribution of any such research to the gap in existing literature on the cyclical nature of the relationship between social determinants of health and IDU.

**Expected Outcomes**

1. Underlying social determinants of health are considered prior to advocating for any changes in enforcement policies.

2. Improvements in the social determinants of health for IDU and their communities are demonstrated through research and experience.

**Potential Lead Agency or Partner Agencies**

- AIDS Saskatoon
- Corrections Canada
- John Howard Society
- Family Healing Circle Lodge
- Persons Living with AIDS (PLWA)
- Saskatchewan Corrections & Public Safety
- Saskatoon Health Region—Public Health Services
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Integrated Drug Unit
- Saskatoon Tribal Council
Recommendation E-2
Advocate for drug addiction to be re-positioned as a health issue, with the promotion of a separate drug court.

Background
Canada’s National Framework for Action (30) provides a series of nine foundational principles to reduce the harms associated with alcohol and other drugs and substances in Canada. The first two principles of this framework state that problematic substance use is a health issue and that it is shaped by social and other factors (30). From an enforcement perspective, the consideration of drug addiction as a health issue involves expanding the definition of IDU to include an understanding of underlying social determinants of health and health risks.

The significance of social dimensions of IDU is described in the background provided for recommendation 4.1 above. Health risks for IDU exposed to incarceration are also significant. The prevalence of HIV within offender populations is approximately ten times greater than that of the general population, with a much higher and growing rate of HCV (31). Of offenders in federal and provincial correctional institutions, 11% report using injection drugs during their present incarceration (32). The combination of these risk factors, particularly in situations where sterile injection equipment is unavailable, creates an environment of extreme risk for dependent IDUs serving a criminal sentence.

The creation of drug courts is, in part, a response to the disproportionate representation of IDU among incarcerated individuals. Among the Canadian offender population in federal institutions, approximately 7 out of 10 self-report engaging in problematic drug use (including alcohol) in the year leading up to their current incarceration (33). Research also demonstrates strong associations between drug use and a broad range of criminal activities in Canada, with over half of Canadian offenders in federal institutions reporting that substance use or abuse was either directly or indirectly related to their current conviction (21). This means that a large portion of offenders in Canadian correctional facilities are serving sentences as either a direct or indirect result of problematic drug use.

The recognition of addictions as a health issue is another factor leading to the establishment of drug treatment courts intended exclusively for cases of drug-related charges. Such courts are now established in several countries, including Canada, the United States and Australia (34, 35). Drug treatment courts facilitate treatment for offenders who meet specific criteria and provide an alternative to incarceration that involves participation in drug treatment programs and an emphasis on rehabilitation. This approach is purported to be more effective for both public health and correctional systems through reduced costs and improved access to treatment options. Unfortunately, few evaluations or systematic reviews are available to assess the long-term effectiveness for individuals participating in programs offered by drug courts (34, 35).
The Toronto Drug Court, established in 1998 as Canada’s first drug court, was designed to address the unique needs of non-violent offenders who use cocaine or opiates (36). The program involves integrated treatment, collaboration among criminal justice and treatment personnel, frequent drug use testing, regular court monitoring and reporting, and a continuum of treatment and referrals to community services for rehabilitation (36). Participants attend treatment, report to court and observe proceedings, and provide urine for analysis when required. The court adopts a harm reduction approach, allowing for some flexibility and recognizing that relapses may occur. Rewards, such as commendation and less frequent reporting, are offered to participants demonstrating progress, motivation and commitment.

Process, outcome and cost-effectiveness evaluation of the Toronto Drug Court began with its opening in 1998. To date, only preliminary results are available. In the first eighteen months of operation, only 10 of 198 participants in the program had successfully ‘graduated’; though 95 participants remained in or had completed the program, for a reported retention rate of 46% (36). For comparison, Australia’s New South Wales Youth Drug Court pilot program reported a 39% successful completion rate within the first eighteen months of the program (37).

Regina is currently piloting a drug treatment court model for the province (38), offering alternative sentencing and treatment options to individuals charged with drug-related offences (5). As Saskatchewan continues with its drug court pilot program in Regina, it is important to consider how various stakeholders understand and are responding to the program. Additionally, as drug addictions are repositioned as health issues, service providers in the criminal justice system, public health and treatment services must understand how social determinants of health and health risks are related to drug use. The intersection of health with the legal system further requires service providers to understand how drug and traditional courts work, what sentencing options are available and what correctional processes are involved for individuals convicted of drug-related crimes.

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Facilitate seminars open to service providers in the criminal justice system, public health and treatment services that provide education and opportunities to discuss drug addictions, social determinants of health related to IDU and treatment services available in the community.

2. Facilitate seminars open to service providers in the criminal justice system, public health and treatment services that provide education and opportunities to discuss drug and traditional court processes, sentencing options and correctional procedures, with particular attention to common challenges and strengths of each.
3. Establish an interim line-of-communication plan intended to complement the on-going development of the IDU Continuum of Care, drawing from available resources (e.g. Services Directory, under development by the Street Health program) to:
   
a. Facilitate coordination between public health, addictions services, and police.

   b. Encourage referrals to the Drug Court being piloted in Regina.

4. Advocate for the incorporation of harm reduction approaches in local law enforcement efforts, recognizing problematic drug use as a health issue and improve coordination with treatment and rehabilitation services.

5. In coordination with Recommendation 2.2 (Harm Reduction Pillar--develop an intensive education program), advocate for changes within Correctional Services to support residential drug treatment, harm reduction strategies and education, and transition programming.

**Long term strategies:**

1. Collaborate with members of the criminal justice system, addictions services, members of the IDU community, and public health to:

   a. Discuss perceived progress, successes and challenges of the Regina Drug Court pilot program.

   b. Provide feedback to appropriate stakeholders on the current structure, conditional or alternative sentencing options, and successes/challenges of the Regina Drug Court pilot program.

   c. Develop further conditional or alternative sentencing options for drug courts that are focused on client-centered programming and follow-up.

   d. Advocate for evaluative research to assess the effectiveness of the pilot Drug Court.

   e. Advocate for the establishment of evidence-based best practices for enforcement issues related to sentencing of individuals charged with drug-related crimes.

2. Advocate for the adoption of a harm reduction approach to IDU offenders within the criminal justice system, including more referrals to the Regina Drug Court, police-ordered referrals for drug treatment and education, and greater efforts in community-based follow-up.
Expected Outcomes

1. Service providers within the criminal justice system, public health and treatment services demonstrate greater understanding of both the health and legal dimensions of IDU.

2. Communication and coordination between public health, addictions services and police is enhanced, as demonstrated in part by a greater number of referrals to drug treatment and education by police.

3. Local law enforcement policies incorporate a greater emphasis on harm reduction, as demonstrated by a greater number of referrals to the pilot Drug Court and greater involvement of citizens in development of enforcement policies.

4. One or more working group established under the enforcement pillar actively contributes to the establishment of best practices for sentencing of drug-related convictions.

Potential Lead Agency or Partner Agencies

- John Howard Society
- Saskatchewan Crown Prosecutor
- Saskatchewan Defense Counsel
- Saskatchewan Justice
- Saskatoon Health Region—Public Health Services
- Saskatoon Integrated Drug Unit
Recommendation E-3
Advocate for the use of diversionary programs and alternative sentencing for youth charged with a minor drug-related offense.

Background
Youth who use injection drugs are at high risk for exposure to blood-borne pathogens, including HIV and HCV. A large percentage of Canadian youth use or have experimented with the use of illicit drugs. According to the 2004 Canadian Addiction Survey, 10.5% of youth aged 15-17 and 30.6% of youth aged 18-19 report having used of any five illicit drugs (cocaine, speed, ecstasy, hallucinogens, or heroin) in their lifetime. When the use of cannabis is included, these percentages increase to 39.5% and 70.9%, respectively (39).

Problematic drug use can also increase the risk of becoming involved in or being charged with a drug-related crime. Of drug offence charges laid in Canada for the year 2000, 14% were against youth. Two-thirds of drug-related youth charges were for possession (3).

Given the proportion of youth who use or experiment with illicit drugs, the risks these youth are exposed to, and the distinct needs of youth for specialized services (40), particular attention needs to be given to reducing health and social risks and enhancing options available to youth.

The 2003 Youth Criminal Justice Act (YCJA) (41) directs current enforcement policies for youth. Leading into the adoption of the YCJA, Canada’s incarceration rate was higher than any other Western countries and Saskatchewan’s was higher than any other Canadian province (42). The YCJA was developed with the intention to reduce these rates and provide a more comprehensive and supportive framework to direct the response to youth criminal offenses. The YCJA contains provisions that increase extrajudicial enforcement responses for less serious offences for first-time, non-violent offenders (43). These alternatives include:

- Repairing the harm caused to the victim and the Community.
- Providing an opportunity for victims to participate in decisions.
- Ensuring that measures are proportionate to the seriousness of the offence.
- Encouraging the involvement of families, victims and other community members.

Police are also required to consider extrajudicial alternatives before charging a young person. These alternatives for police include:

- Taking no further action.
- Informal warnings.
More formal Police Cautions in the form of a letter from police to the young person and their parents or a request for both to appear at a police station to talk to an officer.

Crown cautions, which are followed up by prosecutors after referral from by the police.

Referrals of young persons by police to community programs or agencies, including recreation programs and counseling agencies, that help them not to commit offences.

Extrajudicial sanctions for young people who admit responsibility for an offence and cases that cannot be adequately dealt with by a warning, caution or referral. Sanctions may be followed by court proceedings.

If charged with a drug-related offense or offered any extrajudicial measure in response to a drug-related offense, otherwise hard-to-reach or marginalized youth may become part of a captive audience, either through involvement in young offender programs or by using the criminal justice system as a point-of-entry into supportive services (44). Through these programs and services, youth who use injection drugs or who are at risk of initiating injection drug use can be offered opportunities for intense education and follow-up (45). A variety of education approaches should be used, including (45):

- The use of appropriate peer or role model speakers in educational sessions, seminars or peer-led discussion groups.
- Group interventions.
- Individual counseling.
- Involvement of Aboriginal role models or Elders in programs and supports for young offenders who identify with an Aboriginal or First Nations culture.
- Provision of information about blood-borne pathogens, encouragement for and availability of testing for blood-borne pathogens.
- Provision of information about, encouragement for, and availability of Hepatitis B immunization.
- Provision of opportunities to learn about and access (upon discharge for youth in correctional facilities) community-based resources and support and harm reduction initiatives.

Saskatoon’s Youth Addiction Strategy (1) draws attention to the need for alternative responses and support for youth charged with drug or addictions-related offenses. The strategy recommends that children and youth should not be kept in jail for addictions (1) and calls for improved and expanded education, community awareness and treatment services specifically engaging youth in their development and delivery.
Suggested strategies for this recommendation:

**Short-term Strategies**

1. In coordination with Recommendation E-6 (Establish a program of action-research), engage in a collaborative process of critical reflection on current practices and service provision for youth charged with drug-related offenses.

2. Facilitate seminars open to service providers and community members, including youth, that provide education and opportunities to discuss drug addictions, social determinants of health related to IDU, treatment services available in the community, and the Youth Criminal Justice Act.

3. Encourage alternative sentencing for youth charged with drug-related offenses that incorporates bringing youth who are high-risk or who are charged with drug-related offenses into a ‘circle of care’ which includes both families and relevant agencies and ‘adults of trust’ as supports to address underlying problems.

4. Consider collaborating with other cities sharing the four-pillar approach to create political leverage in national advocacy for greater use of extrajudicial alternatives, including options for access to treatment services, for youth drug offences.

**Long-term Strategies**

1. In collaboration with stakeholders from the criminal justice system, community-based organizations, public health and youth, establish a diversionary process for youth charged with minor drug offenses.

2. Incorporate the use of appropriate peer or role model speakers in educational sessions, seminars or peer-led discussion groups, group interventions, individual counseling, and the involvement of aboriginal role models and Elders in programming for youth identified as at-risk or charged with a drug-related offense.

3. Incorporate age-appropriate, interactive educational programs addressing blood-borne pathogens for youth identified as at-risk or charged with a drug-related offense.

4. Incorporate opportunities for youth at risk or youth charged with a drug-related offense to learn about and access community-based resources and harm reduction initiatives.

5. Consider developing a best practices document for enforcement issues related to youth and drugs.

6. In collaboration with stakeholders from the criminal justice system, community-based organizations, public health and youth, establish and offer a diversion program for youth upon discharge from a correctional institution or residential program.
7. In coordination with Recommendation E-3 (Positioning of addictions as a health issue with promotion of a separate drug court), advocate for the expansion of the pilot drug court program to include the creation of a separate youth drug court from the criminal justice system.

8. Advocate for the inclusion of a youth coordinator in enforcement services who would work with other service providers to fast track youth moving through extrajudicial alternatives, such as a police or crown cautions or sanctions, and to monitor outcomes.

9. Consider participating in national forums or holding a provincial forum to review current law and regulations surrounding youth and drug charges.

**Expected Outcomes**

1. Extrajudicial alternatives for youth are expanded to be more comprehensive, to include options for access to treatment services, to be more responsive to youth-specific needs and be used with greater frequency.

2. The enforcement pillar working group(s) actively contributes to the establishment of best practices in sentencing of youth charged with a drug-related offense.

**Potential Lead Agency or Partner Agencies**

- Kilburn Hall Youth Centre
- Saskatchewan Crown Prosecutor
- Saskatchewan Defense Counsel
- Saskatchewan Ministry of Justice
- Saskatoon Communities for Children
- Saskatoon Community Youth Arts Program
- Saskatoon Core Neighborhood Youth Co-op
- Saskatoon Health Region—Public Health Services
- Saskatoon Integrated Drug Unit
- Saskatoon Tribal Council
- White Buffalo Youth Lodge
Recommendation E-4
Consider advocating for laws that decriminalize the possession of drugs for personal use.

Background
Decriminalization has emerged in Canadian political forums and is discussed in both Vancouver and Toronto’s four-pillar drug strategies (2, 4). Stakeholders at the October 2005 meeting felt that advocacy for the decriminalization of the possession of small amounts of drugs for personal use was an important point to consider in the development of a comprehensive drug strategy.

As described earlier in this section, asking for, buying or possessing a controlled substance for non-medical purposes is considered a criminal offence under the Controlled Drugs and Substances Act (9). The criminalization of these activities is guided by internationally agreed upon UN covenants (7, 46, 47). Despite ongoing political pressure to participate in the so-called War on Drugs, the effectiveness of criminalizing certain drugs and substances is widely questioned.

Critics of the current predominant policies for drug control highlight the lack of evidence for the effectiveness of criminalization to reduce crime, drug use or drug supply. Many argue that prohibition policies and criminalization have led to the development of organized crime, perpetuation of violence associated with drug traffic and supply and the creation of excessive enforcement-related costs (4, 8, 13, 14, 26). Criminalization is also criticized for contributing to social marginalization of people who use illicit drugs by dichotomizing images of ‘respectable youth’ who are vulnerable to ‘social deviants’ (13, 48).

Decriminalization is not a singular response or policy change; rather, it represents a spectrum of policy options that would change how drugs are made available, what activities are considered criminal offenses and what penalties are associated with these criminal offenses. Each option within this spectrum offers unique implications. These policy options include (26):

- ‘Free Market’ legalization, allowing an open market system to sell drugs and promote currently controlled substances, including advertising and maximization of sales.

- Legalization with product restriction, aiming restrictions at manufacturers, packagers, distributors, wholesalers and retailers who prepare and distribute currently controlled substances. This model is used for the sale, promotion and packaging of tobacco and prescription drugs.

- Market regulation, extending product restrictions to include regulations that restrict purchasers. Such restrictions would regulate access to drugs and might include age, degree of intoxication, volume rationing, proof of ‘need’ in order to purchase, required training for purchasers, proof of residency with purchase, or limitations in allowed locations for use.
- Allowing drugs to be available on prescription so that physicians could be allowed to prescribe currently controlled substances for medicinal or maintenance purposes.

- Decriminalization, which would remove legal sanctions currently associated with drug-related charges. This term is often confused with legalization, which applies to how drugs can be legally available.

- De facto decriminalization or de facto legalization, implying a collective agreement to ignore existing laws without charging the law. This model has been used in the Netherlands for many years and can be used to allow for a transition period to test out potential policy options under consideration.

- Depenalization, allowing for significant reduction in the penalties associated with possession of currently controlled substances.

- Criminalization, maintaining the enforcement of current laws prohibiting controlled substances. ‘Zero tolerance’ policies align with this option, under which individuals caught possessing or trafficking controlled substances can be charged, fined, given a criminal record, and/or face incarceration.

Suggestions of ways to approach:

**Short-term Strategies**

1. Review the literature presented in the background for this recommendation, with specific attention to the models available for decriminalization or legalization and the evidence in support of and against each.

2. As a working group, openly explore the options and debates presented in the literature through active dialogue, with a facilitator if necessary.

3. Facilitate interactive, informative sessions to open community dialogue around options for decriminalization or legalization that include service providers in the criminal justice system, enforcement officers, public health, academics, IDUs and the community as a whole.

4. Consider adopting a policy evaluation tool, such as the Health Impact Assessment as described in Recommendation E-1, to examine the potential positive or negative impacts of the adoption of a particular model of decriminalization or legalization.

**Long-term Strategies**

1. Collaboratively establish a position statement for the enforcement pillar declaring a unified, informed and evidence-based position related to models of decriminalization or legalization.

2. Share this position statement with other members of the enforcement pillar for validation.
3. Share the position statement with stakeholders in other pillars.

4. Consult and collaborate with other cities adopting a four-pillar approach to engage in dialogue about the implications of and evidential supports for different models of legalization or decriminalization, with the intent to collaborate on advocacy efforts for changes to the Controlled Drugs and Substances Act.

5. Communicate the position statement to community, service providers and partner agencies as a tool for political advocacy and education.

6. Consider incorporating an exploration of the health and social outcomes associated with any potential policy changes related to legalization or decriminalization, potentially through the use of *Health Impact Assessment*, into any program of research supported by the enforcement pillar.

7. Consider the potential contribution of any such research to the gap in existing literature on the cyclical nature of the relationship between social determinants of health and IDU.

**Expected Outcomes**

1. Stakeholders in the enforcement pillar understand and appreciate the perspective of other members related to decriminalization.

2. Stakeholders from the criminal justice system, enforcement services, public health, and community organizations engage in active dialogue with the community to explore the options available and their implications.

3. A collective, united position statement is established.

4. Active advocacy efforts are made within the Saskatoon Health Region at a national level.

**Potential Lead Agency or Partner Agencies**

- IDU-user groups
- Saskatchewan Department of Justice
- Saskatoon City Police
- Saskatoon Health Region—Public Health Services
**Recommendation E-5**  
Advocate for enforcement efforts in policing and through the criminal justice system to be focused on supply reduction.

**Background**  
Supply reduction is an important component of enforcement and harm reduction efforts related to illegal drugs (49). A study in Australia took advantage of an unusual and sudden drop in the availability of heroin (and its subsequent 112% increase in price per gram) to examine the impact of supply reduction on drug consumption, drug expenditures and rates of overdose among heroin users (49).

Demand for heroin was found to reduce by 56% following the dramatic reduction in supply. The study demonstrated a statistically significant reduction in both heroin consumption and heroin overdoses following reduced supply; however, 75% of those surveyed reported using cocaine to ‘make up’ for the reduction in their heroin use. A significant proportion of heroin users reported having increased their participation in acquisitive crime as a result of the jump in heroin prices; however crime statistics for the period showed no significant changes (49). The authors argue that supply control policy contributes to the prevention of, or at least an easing up on, some of the harms associated with heroin.

There is a possibility of unintended adverse consequences for reducing the supply of drugs in areas where demand remains unchanged, particularly in the context of prohibition and the existence of black-markets for drugs and organized crime. The reduction in heroin consumption in Australia following the dramatic reduction in supply coincided with increased consumption of cocaine (50). Economic arguments suggest that the costs of a competitive market are passed on to users in the form of higher drug prices (51, 52) and may lead to increases in acquisitive crime to fund users costs (53).

Stakeholders at the October 2005 meeting felt that the enforcement efforts needed to be directed away from users towards targeting drug suppliers and traffickers; instead focusing treatment and harm reduction efforts at IDU. They recommend creating a top-down policy for enforcement, with harsher penalties for traffickers and greater emphasis on destabilizing organized crime.

**Suggestions of ways to approach recommendation:**  
**Short-term Strategies**  
1. Advocate for enforcement efforts to be directed at supply reduction, collaborating closely with the other three pillars (prevention, harm reduction and treatment) to ensure that any unintended, negative consequences are off-set by efforts to reduce demand and harms associated with IDU.
2. Advocate for harsher and more consistent penalties for charges related to drug trafficking to increase accountability and create greater deterrence this crime.

3. Advocate for the severity of penalties to be delegated in a top-bottom manner, from suppliers to drug traffickers, considering harsher penalties for those responsible for upper levels of the drug-supply chain.

**Long-term Strategies**
1. In coordination with Recommendation F-6 (Program of Action Research), work collaboratively to consider:
   a. The community and individual dimensions of drug supply and demand.
   b. The multiple potential impacts of reduced drug supply
   c. How advocacy efforts for supply reduction can be coordinated with Recommendation E-3 (decriminalization) to contribute to a re-orientation of federal drug policies.

**Expected Outcomes**
1. The supply of illegal drugs and its associated negative consequences demonstrate a net reduction.
2. Sentencing of crimes related to trafficking or distribution of illicit drugs demonstrates greater consistency and severity.
3. Advocacy efforts in supply reduction consistently consider implications of doing so in the context of continued demand and the consequences of a black-market for illegal drugs.

**Potential Lead Agency or Partner Agencies**
- Saskatchewan Crown Prosecutor
- Saskatchewan Defense Counsel
- Saskatchewan Justice
- Saskatoon City Police
- Saskatoon Health Region—Public Health Services
- Saskatoon Integrated Drug Unit
References


(9) Department of Justice Canada. Controlled Drugs and Substances Act. 1996 20 June;C-38.8.


(11) Engele J. Meeting with the Saskatoon Integrated Drug Unit. Saskatoon, SK; 2006. [Personal Communication: 4 Dec 2006].


(33) Canadian Centre on Substance Abuse. Substance Abuse in Corrections: Frequently asked questions. Ottawa, ON: Canadian Centre on Substance Abuse; 2004.


Part 7: Treatment & Recovery

Introduction

Treatment and recovery interventions improve the physical, emotional, psychological health and well-being of current and former IDUs through various psychosocial and psychopharmacological therapeutic methods. The goal of treatment is to abstain from or to manage the use of injection drugs. Effective treatment interventions are evidence-based, accessible, flexible, and actively engage the client and their circle of care in partnership with service providers who are involved in their treatment and recovery plan.

In Canada, most drug treatment and recovery programs and services are governed by provincial or territorial jurisdictions. The role of the federal government is to collaborate with the provinces and territories to (1):

- Initiate development of innovative treatment and recovery programs.
- Evaluate existing programs and services.
- Identify best practices in the drug arena.
- Disseminate information nationwide.
- Govern the Alcohol and Drug Treatment and Rehabilitation Program (a program providing funding to provinces and territories to improve accessibility)

Treatment and recovery services across Canada involve a spectrum of services, including (1):

- Acute detoxification services.
- Early identification and intervention.
- Assessment and referral.
- Counseling.
- Life skills training.
- Case management.
- Therapeutic intervention.
- Referral to community-based social support services.
- After-care and clinical follow-up.

Treatment can be provided on an inpatient, outpatient, or day patient basis— including short-term and long-term residential care. Specific treatment and recovery programs and services have been developed to address the unique needs of certain target groups of the population, such as women, youth, Aboriginal peoples, people with concurrent...
mental health problems, and inmates in correctional facilities. Current drug legislation supports alternatives to incarceration such as mandatory treatment and rehabilitation, where appropriate.

There has been significant evolution of drug treatment and rehabilitation over the past several decades in Canada (2). A brief outline of the history is presented in Table 7.1.

Table 7.1: Brief outline of the history of drug treatment and rehabilitation in Canada

<table>
<thead>
<tr>
<th>Period</th>
<th>Advances in drug treatment and rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1950s</td>
<td>Treatment models were dominated by moralistic attitudes. Very few people had access to treatment, as they were perceived as having personality defects or lacking will power.</td>
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<tr>
<td>1950s-1960s</td>
<td>Alcoholism was seen as a preventable and treatable disease, rather than a symptom of moral weakness. This lead to the popularization of the 12-step recovery programs.</td>
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<tr>
<td>Late 1950s</td>
<td>Most provinces and territories established departments, commissions, or foundations to provide or coordinate addictions treatment. As addictions other than alcohol emerged, mandates were expanded and new services were developed.</td>
</tr>
<tr>
<td>Mid 1960s</td>
<td>Characterized by a rapid expansion of addictions services. British Columbia trialed compulsory treatment for people addicted to heroin, however there were problems with civil rights and public perception.</td>
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<tr>
<td>&gt;1980s</td>
<td>Provincial and territorial agencies became more autonomous within their health and social service systems. Services evolved to become more diverse and specialized to meet the needs of different target groups. Various treatment models based on cognitive, behavioral, and social theories emerged.</td>
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</tbody>
</table>

Addictions research and longitudinal studies of treatment outcomes have resulted in the shift in treatment philosophy from a high threshold model (abstinence-based) to one with a harm reduction view that sees abstinence as a desired ultimate outcome, but not essential to accessing ongoing treatment. Less than 10% of people who use substances will consider entering abstinence based programs (3) and the long term recovery rate is about 15% for those who do (4).

A number of theories and models and have guided substance abuse treatment systems in Canada, namely the Trans-theoretical Model of Change, which organizes the treatment of addiction problems within a bio-psycho-social framework. This ‘stages of change’ model guides the provision of appropriate treatment services to align with clients’ level of motivation or readiness to change (Stages of change: Pre-contemplation, Contemplation, Preparation, Action, Maintenance, Relapse) (5).

Treatment for drug addictions is demonstrated as cost-effective. A recent Alberta Alcohol and Drug Abuse Commission report concluded that for every dollar invested in treatment, $7.14 was saved in increased productivity and reduced health and justice
system costs after one year (6). Moreover, it was found that drug treatment was seven times more effective than law enforcement (arresting and imprisoning buyers and sellers), 10 times more effective than interdiction (stopping drugs at the border) and 21 times more effective than attacking drugs at their source (attacking drug trade abroad), in reducing cocaine consumption (6).

Stakeholder consultation has underscored the notion that treatment is only part of the continuum of services required for recovery from substance abuse. Detoxification is the initial step on the recovery pathway, followed by a constellation of ongoing therapeutic services which continually assess the client’s physical, psychological, and socioeconomic status. Additionally, treatment involves the analysis of environmental risk factors contributing to drug use, as well as the identification of relapse triggers and coping mechanisms. Treatment also involves primary medical care and psychiatric care if indicated. The goal of treatment is to attain a higher level of social functioning by reducing risk factors, enhancing protective factors, and thus decreasing the possibility of relapse (7). The recovery process also includes post-treatment counseling and support, refinement and enhancement of strategies to avoid relapse, and engagement in ongoing relapse prevention and follow-up in the community.
Best Practices in Treatment

The Office of Alcohol, Drugs and Dependency Issues, Health Canada have developed a comprehensive list of best practice guidelines in substance abuse treatment and rehabilitation (8). These best practices serve as a framework from which treatment and recovery programs can be built, adapted and assessed for comprehensiveness, appropriateness, and effectiveness.

*Pharmacotherapies,* if used in a controlled setting, can be an effective adjunct to other forms of treatment and should be considered. Methadone, in adequate doses and with supportive therapy, is effective in reducing illicit opiate use, criminal activity and HIV transmission. Methadone therapy can improve social functioning, physical health and productivity, and in some cases, can lead to cessation of heroin use. Better outcomes are achieved with longer retention in treatment.

*Flexible and individualized services* are required to meet the needs of individual clients. Guidelines for the selection of appropriate services are also needed. Although the literature does not yet provide strong evidence by which to match clients to specific treatment interventions, it does not mean that all clients require the same types of services.

*Group treatment* is effective and should be considered and offered unless otherwise contraindicated.

*Outpatient services* should be offered when appropriate. Research continues to support the relative cost-effectiveness of treatment provided on an outpatient basis to that provided on a residential basis; but this does not deny that some people with substance use problems need short or longer-term supportive accommodation. However, those who are provided this type of accommodation could still benefit from participating in outpatient or day programs for help with substance abuse and other problems.

Better treatment outcomes have been achieved for clients with fewer problems and more resources. This indicates the need to research and develop effective interventions for those who currently have a poorer prognosis and consideration of a case-management approach when needed.

*Therapy* should be offered as part of a comprehensive treatment and recovery program. Appropriate therapy by competent counselors with strong interpersonal skills, such as empathy and the ability to forge a therapeutic alliance with the client, is associated with an increase in positive treatment outcomes.

*Mandated treatment* can be effective and should be given equal priority as non-mandated cases. Despite debate in the current literature, there is some evidence of the efficacy of mandated treatment in the context of civil commitment for heroin abuse. Legally mandated clients are no less suitable candidates for treatment than others.
Addressing the unique needs of women in treatment and recovery programming is critical for their success. There is insufficient evidence to support the provision of specific types of interventions for women; however, it is clearly important to consider barriers to treatment and provide a range of modifications and support services (e.g. scheduling sessions while children are in school, the use of self-help materials, provision of child care services, transportation). Women may also require specific ancillary services (e.g. services related to pregnancy, sexual abuse counselling, parenting skills training and vocational assistance) to meet their treatment and recovery goals.

Addressing the unique needs of adolescents in treatment and recovery programming is critical for their success. Adolescents respond best to flexible approaches which adjust to individual needs. Important program elements demonstrating success include family therapy, behavioural skills counselling, family and peer support and continuing care. Ancillary services, such as the availability of school for dropouts, vocational counselling, recreation services, psycho-social development, crises counselling and sexuality counselling, are also important.

Addressing the unique needs of seniors in treatment and recovery programming is critical for their success. Seniors are often reluctant to acknowledge a substance use problem or to seek help from specialized services. Community-based treatment provided in the broader context of support for health and activities of daily living, using a client-centred, flexible and holistic approach, is more effective.

Integrated services for addictions and mental health are more effective than fragmented services. Providing integrated services for people with co-occurring substance use and mental health problems holds more promise than offering services in sequence or parallel. Close liaison and coordination to enhance referral and case management need to occur among the respective specialized services in a community. Training appears crucial, not only for staff of respective specialized services, but also for social services and correctional staff where these clients often present themselves. Excluding people with mental health problems from addictions treatment and excluding those with alcohol or drug problems from mental health treatment should, in general, be discouraged.

Addressing stigma, discrimination and marginalization is an important component of building effective, comprehensive treatment and recovery programs. Injection drug users with HIV/AIDS tend to be marginalized in their communities, and it is difficult for them to access appropriate care and treatment. The very considerable health risks facing this population call for better coordination of services and more innovative treatment measures to reduce this harm, particularly among Aboriginal people, women and those in prison settings.

Case management and improved coordination across services improves client outcomes. Populations with complex needs require improved access to treatment. Effective case management is particularly important to meet the unique and often multiple needs of these clients coping with multi-dimensional issues related to substance use. Enhancing efforts to build awareness of and access to informal help groups and self-instructional material, involving community services in identifying and
supporting clients with substance abuse problems, and providing specialized services through outreach efforts can contribute to improving coordination and accessibility.

*Increasing awareness* of available services may improve the social accessibility of treatment and recovery services. The majority of those struggling with alcohol or other drug addictions do not seek help, especially not from specialized addiction services. Efforts may therefore be required to increase awareness of specialized addictions, treatment and recovery services among the general population and among social and health service providers.

*Creating continuity in care* through coordinated services is most effective. There is consensus in the literature that clients are better served when they can access a range of flexible and individualized services spanning the specialized and non-specialized sectors, linked through some form of coordination and case management, and accounting for the needs of special populations.

*Service providers’ awareness of other services* can improve accessibility for clients. Though by its nature it is difficult to evaluate the efficacy of attendance at AA or other mutual aid groups, many people find such groups of benefit, and clinicians should make themselves familiar with AA and other mutual aid groups and provide information and support to their clients in the use of these resources.
## Treatment Recommendations

The following recommendations have been developed from strategic planning with stakeholders in the SHR. Each recommendation offers specific, concrete strategies for stakeholders to consider. These strategies are based on review of best practices and relevant reports, as well as stakeholder consultation. Short-term strategies are those that build upon existing resources and infrastructure, whereas long-term strategies may require additional support or funding for implementation.

<table>
<thead>
<tr>
<th>T-1</th>
<th>Understand and reflect in treatment the principle that injection drug use is first and foremost a health issue with social consequences.</th>
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<tbody>
<tr>
<td>T-2</td>
<td>Develop a centralized, 24-hour manned depot to provide treatment options and referrals, drug-related information and assistance.</td>
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<tr>
<td>T-3</td>
<td>Collaborate to improve information sharing and coordination of treatment services for injection drug users.</td>
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<tr>
<td>T-4</td>
<td>Ensure that progression from detoxification to treatment services is timely and responsive to individual client needs.</td>
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<tr>
<td>T-5</td>
<td>Advocate for treatment and detoxification services that are tailored for injection drug use.</td>
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<tr>
<td>T-6</td>
<td>Develop youth-specific treatment centres.</td>
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<tr>
<td>T-7</td>
<td>Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.</td>
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<td>T-8</td>
<td>Work in partnership with clients and their circle of care in a coordinated effort to plan and manage the recover process.</td>
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<td>T-9</td>
<td>Recognize that cultural and spiritual experiences are integral to the recovery process for IDU clients.</td>
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<td>T-10</td>
<td>Program family involvement, support and education into the treatment and recovery process.</td>
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<tr>
<td>T-11</td>
<td>Address barriers to the access and availability of treatment and recovery services for IDU clients.</td>
</tr>
<tr>
<td>T-12</td>
<td>Ensure a flexible and supportive client-centered plan for follow-up in the community.</td>
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</tbody>
</table>
Recommendation T-1
Understand and reflect in treatment the principle that injection drug use is first and foremost a health issue with social consequences.

Background
The public health and social impacts of injection drug use in Canada are extensive, complex and devastating (1). IDU is correlated with acquiring and transmitting blood borne infections such as HIV, hepatitis virus and other communicable pathogens via unprotected sex, the sharing of injection equipment and other drug paraphernalia, and perinatal transmission. Additionally, epidemiological studies have shown that between 30-60% of people with drug problems experience concurrent mental health diagnoses (e.g. personality disorders, major depression, schizophrenia, and bipolar disorder) (9).

Research has shown that drug addiction is associated with actual changes in brain physiology. This interferes with an individual’s ability to make decisions and can lead to compulsive drug craving, seeking and use (10). Drug dependency is defined as a substance-related disorder by the American Psychiatric Association (11). In this context, the management of chronic addiction to injection drugs in the community should parallel models of other chronic diseases such as diabetes and hypertension.

The social consequences of IDU include crime, family dysfunction, child abuse, unemployment, inadequate housing, discrimination, low literacy, and low self esteem (12). These social consequences parallel the social determinants that have been associated with an increased risk of IDU (1).

IDUs are a marginalized population, often with psychological, physical and social problems that are exacerbated by a lack of societal support and conflicts with enforcement. Together, these factors make it difficult for IDUs to comply with most treatment regimes (12). Philosophical barriers between stakeholders need to be addressed in order to enable the health view of IDU and its social consequences to be programmed into the treatment and recovery process.

Suggested strategies for this recommendation:

Short-term Strategies
1. Establish a working group within the treatment pillar with participants representing community, IDUs, partner agencies and service providers. The working group will be responsible for considering and addressing the strategies of this recommendation.

2. Discuss differing philosophies and establish consensus on the principles of IDU that are to be adapted in the SHR. Share these principles with members of the Treatment &Recovery working group and with stakeholders from other pillars.

3. Foster community ownership of the health and social consequences of IDU, through forums including presentations, meetings and focus group discussions with various groups (stakeholders, partner agencies, community members and IDUs).
4. Facilitate consultation, information sharing and communication with the general public.

**Long-term Strategies**

1. Foster a collaborative approach and enhance awareness of different stakeholder roles and philosophies by developing multidisciplinary training for all stakeholders involved in treatment delivery (e.g. physicians, counselors, community-based social support services etc.)

2. Expand education curricula for medical, nursing, pharmacy and other healthcare students to have a greater emphasis and time allocation to address issues associated with IDU and other addictions. Some topics may include addictions medicine, attitudes and values, substance use counseling etc.

3. Develop peer education targeted training for stakeholders working directly or indirectly with IDUs and their families. This would include orientation sessions for new staff.

4. Identify a champion to raise the profile of IDU as a health issue with social consequences, amongst medical professionals, partner agencies and the community.

**Expected Outcomes**

1. A common understanding and vision of the health and social consequences of IDU by all stakeholders.

2. IDU is articulated as a health issue within all strategies and documents adopted or produced by the Treatment & Recovery working group.

3. Enhanced client-centered care in the treatment and recovery process is based on the needs of IDU clients rather than the influence of service provider philosophy.

**Potential Lead Agency or Partner Agencies**

- Community Addiction Services
- Narcotics Anonymous
- Physicians certified to prescribe methadone
- Saskatchewan Health
- Saskatoon Health Region—Emergency Services
- Saskatoon Health Region—Mental Health and Addictions
**Recommendation T-2**
Develop a centralized, 24-hour manned depot to provide treatment options and referrals, drug-related information and assistance.

**Background**
IDU clients are often local-centric, familiar or comfortable only within a few blocks of where they live. Services in an unfamiliar part of town are not only difficult to access, but present special challenges. Focus group discussions with IDUs highlighted the following ways to improve services for IDUs (12):

- Establishment of a clinic where various services are co-located within a drop-in centre venue.
- Availability of 24 hours a day counseling with guaranteed confidentiality.
- Non-judgmental staff.

The Care Provider Survey conducted by PHS-SHR identified a number of service gaps and access issues that were of concern to stakeholders, including (10):

- Lack of a satellite/ drop-in infectious diseases clinic.
- Lack of transportation services to access care.
- Lack of centrally located integrated services.
- Lack of an immediate access point with links to multiple services.
- Limited accessibility of pharmacies and treatment centers.
- Limited outreach service sites and hours of operation.

There was consensus among service providers that a mechanism needed to be established to reduce service fragmentation and reduce barriers faced by clients trying to access various healthcare needs (e.g. “one-stop shopping”).

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Explore ways of providing a multidisciplinary approach at appointments (e.g. stronger presence and linkage of services such as public health, mental health, community addictions, infectious diseases, nutrition, justice, education, DCR, mentoring etc.

2. As a working group, review national and international models of integrated care for substance abuse treatment and recovery programming.

3. Explore ways of improving client’s access to services such as relaxing policies on appointments (e.g. giving clients multiple chances to come to appointments while addressing barriers to attendance) as well as providing financial and food incentives for attending services.
4. Continue the coordination of public health nurses from Communicable Disease Control and Street Health.

5. Advocate for the services of an infectious disease consultant two half days per week (or as necessary) at a fixed needle exchange in the core area.

**Long-term Strategies**

1. In conjunction with the Harm Reduction working group, explore the feasibility of piloting a comprehensive addictions centre that provides onsite multidisciplinary services for substance abuse treatment (including injection drugs). Current outreach services could form the basis for the development of a ‘store-front, one-stop shop’ for IDUs that provides some level of service 24 hours a day, 7 days a week. The centre should encompass services across the continuum of care from substance abuse education to post-treatment services and clinical follow-up in the community.

2. Develop a proposal for the establishment of an addictions centre to be considered by the IDU Advisory Committee.

3. Services that should be provided 24 hours a day, 7 days a week include the following and may be staffed by a combination of public health nurse/outreach worker/addictions counselor/clean addict:
   
   a. Hotline/reception that provides information about substance abuse, harm reduction strategies, treatment availability, entry criteria, referrals and other relevant services.

   b. Clinical consultations offering clients immunizations (Hepatitis A and B, pneumonia, tetanus and influenza), anonymous and non-nominal HIV testing, STI testing and management, pregnancy testing, first aid, and other relevant clinical services.

   c. Counseling and crisis intervention for coping with abuse, addictions, suicide or other issues, building on a mentorship, support and advocacy approach.

   d. Harm reduction services, including needle exchange and disposal, condom distribution, and education.

4. Other services may be provided within business hours and include the following:

   a. Access to medical care services, such as infectious disease specialist, methadone assisted recovery program with on-site supervision, psychiatry, or other relevant medical services.

   b. Community-based social support services that facilitate connecting to social services or other support agencies (e.g. housing, finances, childcare, education and training, employment).
Expected Outcomes
1. Improved access and availability of holistic client-centered care for IDUs.
2. Improved treatment outcomes through the provision of multidisciplinary services that are effectively coordinated and co-located.
3. Reduced annual incidence of HIV, particularly among injection drug using populations.

Potential Lead Agency or Partner Agencies
- AIDS Saskatoon
- Community Addiction Services
- Saskatchewan Justice
- Saskatoon Health Region—Infectious Disease Clinic
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services (Oral Health Program, Nutrition Program)
- Saskatoon Tribal Council
- Station 20 West
- University of Saskatchewan
**Recommendation T-3**
Collaborate to improve information sharing and coordination of treatment services for injection drug users.

**Background**
A review of the literature by the Office of Alcohol, Drugs and Dependency Issues, Health Canada, revealed a patchwork of information about substance abuse treatment delivery systems (8). The report noted a general lack of effective coordination among a variety of drug treatment services which vary in type, scope and focus. The issue of coordination of substance abuse treatment delivery systems is of particular concern for the Saskatoon IDU Strategy, as one of its primary goals is to partner around building a continuum of care that enhances coordination of multisectoral programs and services.

Baker (1991) defined coordination as the degree to which collaboration and exchange exists within an aggregation of service providers (13). The goal of coordination is to prevent clients from falling between the gaps between services by reducing the fragmentation, discontinuity, inaccessibility and lack of accountability of specialized services (14).

Stakeholder consultation elicited similar challenges to the coordination of substance abuse treatment services as that reported in the literature (15):
- Unsystematic way in which services are planned and funded.
- Conflicting ideologies and perspectives on the nature of drug problems and thus the most effective assessment and treatment approach.
- The absence of a common framework or language to describe clients and their problems. This is exacerbated by diverse and non-standardized training requirements for personnel in addictions services and other health and social services.
- The range of health, social and correctional services involved in client care and support and thus communication difficulties across the network of multisectoral agencies.
- The complex, multi-dimensional characteristic of substance abuse problems and the challenges of matching clients to appropriate services when the full range of services may not be available and the criteria for matching clients with services lacks a sound empirical base.
- Referral mechanisms involving ‘passive’ recommendations to seek assistance as opposed to active advocacy and facilitation of clients to needed services.
- Non-standardized intake, management and follow-up mechanisms that reduce accountability and monitoring and evaluation of client outcomes.
A key barrier reported by service providers to implementing a comprehensive continuum of care for IDUs is the inability for partner agencies to rapidly and seamlessly share information (10). Most service providers (19/22 or 86%) indicated having a data system in place to track client or program information, although the structure varied considerably from electronic databases to tick or tally sheets. Most agencies who routinely record client information collect basic client demographics such as age, sex, and address. Many respondents indicated that they primarily keep records to measure service volumes (number of client visits, service provided, length of stay, diagnosis). Only a few of these agencies are linked within the health system to SHR or Saskatchewan Health-supported databases, and one is linked with national partner agencies in a Canada-wide crisis housing database.

The sharing of information across services is therefore hampered by different forms of data collection. Moreover, cross referral and feedback remain major challenges, as services operate within their institutional boundaries and the legislated requirements of the Health Information and Privacy Act.

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. As a working group, determine current level of coordination between service providers. To initiate discussions, some key considerations include (8):
   - *Mutual awareness:* Do staff know about each other and their respective programs?
   - *Frequency of interaction:* Do key staff meet to discuss work-related issues?
   - *Frequency and direction of referrals:* How often or how many clients are referred to and from different services in the network?
   - *Frequency and direction of information exchange:* Do services exchange information about programs, services and clients?
   - *Frequency and direction of staff sharing or exchange:* Are staff of different services permanently or temporarily shared or loaned?
   - *Frequency and direction of other resource exchanges:* Do services share funds, meeting rooms, materials or other resources?
   - *Joint activities:* Are there jointly held consultations, case conferences, staff training, intake and assessment, data collection, program design and operations, and program evaluation?
   - *Overlapping boards:* Are there members in common to community boards form different services?
   - *Formalization of agreements:* Have services developed formal agreements to coordinate their activities?

2. Review the Provincial Health Information Protection Act (HIPA). Discuss information needs, confidentiality issues in relation to the HIPA and share implications with members of the treatment pillar and other stakeholders.
3. Review models of electronic common assessment frameworks (ECAF) and determine feasibility and applicability for Saskatoon.

**Long-term Strategies**
1. Develop a proposal for the establishment of an ECAF to be considered by the IDU Advisory Committee.
2. Key requirements in establishing a functional, effective ECAF may include:
   a. Common general needs assessment including medical and social needs.
   b. Development of a care plan in conjunction with client and their circle of care using a case management approach.
   c. Confidential client information that is only accessible by select service providers where applicable.
   d. Linkage to database containing referral criteria and guidelines for immediate referral and facilitation to enable effective referral
   e. Follow-up and monitoring of progress through the IDU continuum of care and in the community.
   f. Production of outcome measurement statistics – e.g. monitoring of demographics, drug use, morbidity trends, client volumes etc.
3. Enhance formal, organized methods of networking to enhance informal activities (e.g. regular workshops, newsletters, and formal associations of services providers).
4. Include participation of local planning and coordinating committees in the job descriptions of program managers working in treatment or recovery service areas.

**Expected Outcomes**
1. Common assessment and referral processes that allow for improved collaboration and coordination of services are established.
2. Continuity of care for individual clients improves through facilitation of a continuum of care with comprehensive referral mechanisms, monitoring and follow-up of clients.
Potential Lead Agency or Partner Agencies

- Calder Centre
- Community Addiction Services
- Larson House
- Saskatchewan Community Resources
- Saskatchewan Health
- Saskatchewan Hepatitis C Clinic
- Saskatchewan Infectious Disease Clinic
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
**Recommendation T-4**
Ensure that progression from detoxification to treatment services is timely and responsive to individual client needs.

**Background**
Detoxification (detox) includes a set of interventions that manage acute intoxication and withdrawal symptoms. It is “not designed to resolve the longstanding psychological, social, and behavioral problems associated with alcohol and drug abuse” (p.9) (16). The Substance Abuse and Mental Health Services Administration (SAMHSA) offer three essential components to detoxification that may occur concurrently or as a series of steps:

- **Evaluation**: Essentially serves as the basis for the initial treatment plan once the client has successfully undergone detox. It entails drug testing and determination of concentration in the bloodstream, screening for concurrent mental and physical conditions, and comprehensive assessment of client’s medical and psychological conditions and social situation.

- **Stabilization**: Involves the medical and psychosocial processes of supporting the client through acute intoxication and withdrawal in order to achieve a medically stable, fully supported, drug-free state. This period should foster family involvement and establishing a circle of care for the client.

- **Fostering entry into treatment**: Involves facilitating clients’ access into drug treatment and social support services.

The challenge for service providers is to reduce the “revolving door” phenomenon of repeated entry into detoxification services. In part, this depends greatly on developing effective linking of detoxification services with treatment services. A research study in the United States revealed the pitfalls of the service delivery system in which only 15-20% of clients who successfully completed detoxification, went on to receive substance abuse treatment (17). This example underscores the need for effective cross linkages between detoxification and treatment services.

Conflicting beliefs exist among stakeholders and the community about the need for direct progression from detoxification to treatment services. The popular belief is that clients should be channeled directly and immediately from detoxification into treatment services and that the waiting period hinders treatment outcomes and may likely result in a loss of clients to the system. However, stakeholder consultation revealed that the lag time between progression from detoxification to treatment services is a necessary part of the recovery process. This period gives the client an opportunity to experience and understand that detoxification is just the first step in the recovery process and without attending treatment services, relapse is highly likely to occur. Moreover, this lag period is viewed as being essential to build social support in preparation for treatment, such as establishing family involvement or a circle of care, stabilizing housing environments, and tending to immediate needs (e.g. acute health complications).
The issue here is seen as the need to enhance collaboration and coordination between service agencies in order to respond to individual client’s needs in a flexible, effective and timely manner. It is recognized that access to addictions treatment services for IDUs is critical because it can reduce some of the impulsive and unsafe behaviors associated with intoxication, such as needle sharing and unprotected sex. Addictions treatment offers a gateway for access to the diverse services, such as psychiatric assessment, social services, HIV prevention, HIV/HCV therapy and other relevant services.

Research suggests a number of variables are associated with whether or not clients will enter treatment upon successful completion of detoxification (18-20). Clients who are less likely to enter treatment after detox are older clients and those with severe drug dependency. Conversely, clients more likely to enter treatment services are those who (are):

- Motivated beyond the pre-contemplation stage.
- Women.
- Employed.
- Have family and social support.
- Have concurrent psychiatric conditions.
- On parole.
- Homeless.
- Have been using drugs for less than 20 years.

The provision of comprehensive support services such as housing, vocational assistance, childcare and transportation has been shown to improve clients’ engagement in treatment by increasing the likelihood of seeking recovery services and remaining in treatment for longer periods of time. Clients receiving supportive services have also demonstrated better treatment outcomes than those who do not receive such services (21, 22). Thus services planning should extend beyond issues of substance dependence to other areas that may affect compliance with the recovery process such as physical safety, access to a safe, stable, and drug-free living environment; food and clothing; financial assistance; health and prenatal care etc.

Addressing individual client needs to ensure effective access to treatment and recovery services, particularly as they transition from detoxification, demands comprehensive assessment of the individual context of each client. Table 7.2 summarizes a series of recommended domains of assessment, providing a brief description of key points for consideration under each domain.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Recommended Assessment Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Conditions &amp; Complications</td>
<td>Infectious illnesses, chronic illnesses requiring intensive or specialized treatment, pregnancy, and chronic pain.</td>
</tr>
<tr>
<td>Motivation/Readiness to Change</td>
<td>Degree to which the client acknowledges that substance use behaviours are a problem and is willing to confront them honestly.</td>
</tr>
<tr>
<td>Physical, Sensory, or Mobility Limitations</td>
<td>Physical conditions that may require specially designed facilities or staffing.</td>
</tr>
<tr>
<td>Relapse History and Potential</td>
<td>Historical relapse patterns, periods of abstinence, and predictors of abstinence; client awareness of relapse triggers and craving.</td>
</tr>
<tr>
<td>Substance Abuse/Dependence</td>
<td>Frequency, amount, and duration of use; chronicity of problems; indicators of abuse or dependence.</td>
</tr>
<tr>
<td>Developmental and Cognitive Issues</td>
<td>Ability to participate in confrontational treatment settings, and benefit from cognitive interventions and group therapy.</td>
</tr>
<tr>
<td>Family and Social Support</td>
<td>Degree of support from family and significant others, substance-free friends, involvement in support groups.</td>
</tr>
<tr>
<td>Co-Occurring Psychiatric Disorders</td>
<td>Other psychiatric symptoms that are likely to complicate the treatment of the substance use disorder and require treatment themselves, concerns about safety in certain settings (note that assessment for co-occurring disorders should include a determination of any psychiatric medications that the patient may be taking for the condition).</td>
</tr>
<tr>
<td>Dependent Children</td>
<td>Custody of dependent children or caring for non-custodial children and options for care of these children during rehabilitation</td>
</tr>
<tr>
<td>Trauma and Violence</td>
<td>Current domestic violence that affects the safety of the living environment, co-occurring posttraumatic stress disorder or trauma history that might complicate rehabilitation.</td>
</tr>
<tr>
<td>Cultural Background</td>
<td>Cultural identity, issues, and strengths that might influence the decision to seek culturally specific rehabilitation programs, culturally driven strengths or obstacles that might dictate level of care or setting.</td>
</tr>
<tr>
<td>Strengths and Resources</td>
<td>Unique strengths and resources of the client and his or her environment.</td>
</tr>
</tbody>
</table>

Suggested strategies for this recommendation:

**Short-term Strategies**

1. As a working group, discuss stakeholder needs and concerns about referral from detoxification into treatment services and examine communication, networking and coordination of services between the two facilities.

2. Review the process of client placement from detoxification services into treatment services in accordance with best practices (23) based on the dimensions of:
   a. Acute Intoxication and/or Withdrawal Potential.
   b. Biomedical Conditions and Complications.
   c. Emotional, Behavioral, or Cognitive Conditions or Complications.
   d. Readiness to Change.
   e. Relapse.
   f. Continued Use or Continued Problem Potential.
   g. Recovery/Living Environment.

3. Review Table 7.2 as a possible framework for an assessment tool to develop comprehensive referral plans from detoxification services to treatment services.

4. Explore ways to facilitate the progression of all clients from detox into treatment programs with particular attention to those whom research and local experience has shown a lower rate of continuation.

5. Improve access to low-threshold treatment programs.

6. Choose strategies that detoxification personnel can use with their clients to promote initiation of treatment and maintenance activities. Examples may include (7):
   b. Reduce time between initial call and appointment.
   c. Call to reschedule missed appointments.
   d. Provide information about what to expect at the first session.
   e. Provide information about confidentiality.
   f. Offer tangible incentives.
   g. Engage the support of family members.
   h. Introduce the client to the counselor who will deliver rehabilitation services.
   i. Offer services that address basic needs, such as housing, employment and childcare.
Long-term Strategies

1. Expand services planning to include an array of supportive services, such as legal assistance, dental care, support groups, interpreters, housing assistance, trauma treatment, spiritual and cultural support, and employment assistance. Efforts should be made to ensure that linkages to these programs involves more than the provision of a phone number, but rather actively assists clients to schedule initial appointments, arrange for transportation and follow through (7).

2. Consider the needs and barriers experienced by special groups and explore ways to facilitate their entry into treatment services. Population groups that may have unique needs include clients with concurrent mental problems, clients living with HIV/AIDS, women, children and youth, and Aboriginal peoples (See also Recommendation T-11).

3. Consider the role of formalized referral mechanisms through contracts or memorandum of understanding to specify institutional obligations (24).

4. Enhance case management as a critical linkage between detoxification services and recovery through the provision of transportation to treatment services, arranging for childcare, assisting with housing needs, or facilitating connections to other complementary support services required by individual clients.

5. Advocate for more treatment providers such as addictions counselors, physicians certified to prescribe methadone, HCV therapy, addictions medicine specialists, psychiatric concurrent care, and other service providers.

Expected Outcomes

1. Clients are facilitated into the most appropriate treatment services in a coordinated and timely manner that supports optimal healing along the recovery process.

2. Improved collaboration, communication and networking between detoxification and treatment services.

Potential Lead Agency or Partner Agencies

- Community Addiction Services
- Saskatchewan Community Services
- Saskatchewan Infectious Diseases Clinic
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
- Saskatoon Health Region—Volunteer Services (Spiritual Care)
- Saskatoon Tribal Council
**Recommendation T-5**
Advocate for treatment and detoxification services that are tailored for injection drug use.

**Background**
A limited range of treatment and detoxification options are currently offered to IDU clients in the SHR. Stakeholder consultation underscored the need to expand detoxification and treatment capacity to include a broader range of therapy options, expansion of programs to accommodate families, incorporation of cultural and spiritual elements, consideration of continued exposure to at-risk social environments, increased collaboration between prevention and treatment services in the community, and a review of the detoxification protocol for injection drugs.

A literature review of treatment and recovery services for IDU highlighted a number of initiatives undertaken nationally and internationally that have shown to be highly effective in improving treatment outcomes for IDUs. These initiatives have also been shown to significantly improve public health and public order and reduce the health and social costs to society. Such initiatives include:

- Methadone Assisted Recovery (MAR) programs.
- Alternative pharmacotherapies.
- Heroin prescription.
- Needle exchange programs.
- Supervised injection sites.
- Drug user groups and networks.
- Provision of harm reduction information and education to drug users.
- Diversion programs.

Although a number of these services are currently provided for IDUs in the SHR, suggestions for enhancement based on best practices are provided below. Some initiatives have not been trialed in Canada, but based on its evaluated successes in a number of countries, warrants consideration and advocacy.
Table 7.3: IDU Drug Treatment Options

<table>
<thead>
<tr>
<th>IDU Drug Treatment Options</th>
<th>Examples of countries successfully using strategy or trialing its use</th>
<th>Best practice implications for the SHR$^2$</th>
</tr>
</thead>
</table>
| **Methadone Maintenance Treatment** | Canada, United States, Australia, United Kingdom, Switzerland, the Netherlands, Germany |  - Closely link other essential services for IDUs, including education programs, outreach services, counseling, needle exchange, and injection drug user networks.  
   - Increase number of physicians certified to prescribe methadone and access to MMT (refer to Recommendation T-7). |
| **Alternative Pharmacotherapies** | | |
| Buprenorphine | Switzerland, United Kingdom, Australia, France |  - Consider feasibility. |
| Codeine | Germany, Switzerland |  |
| Dihydrocodeine | Germany |  |
| LAAM (Levo-Alpha Acetyl Methadol) | Portugal, United States |  |
| Morphine | Guatemala, Mexico, Switzerland |  |
| Pethidine | Guatemala |  |
| Naltrexone | United States |  |
| **Heroin Prescription** | Canada, Switzerland, the Netherlands, Germany, Spain, Denmark, Luxembourg, Australia |  - Expand heroin prescription trials to other cities in Canada, including Saskatoon. |
| **Needle Exchange Programs** | Canada, United States, United Kingdom, the Netherlands, Australia, Switzerland, Switzerland, Germany, Spain |  - Consider piloting needle exchange in correctional facilities in Canada, including Saskatchewan. |
| **Supervised Injection Sites** | Canada, the Netherlands. |  - Consider piloting a supervised injection site in Saskatoon. |
| **Drug User Groups and Networks** | Widespread formal and informal groups and networks. Particularly successful in Australia. |  - Review need for formal drug user groups and networks in the SHR. |

$^2$ These best practices implications for the SHR are further expanded below in the suggested strategies for this recommendation.
| Provision of harm reduction information and education to drug users | Widely used. | Consider expanding harm reduction information and education to other sectors in addition to public health and addictions services. |
| Diversion Programs | Canada, United States, Australia, Ireland, European Union | See Recommendation E-2. |

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Conduct a needs assessment of treatment services for injection drugs with a focus on areas including:
   a. Treatment options, protocols, care pathways, referral mechanisms.
   b. Service load, waiting list timeframes, case management, resources.
   c. Barriers to access.
   d. Type of drug admissions.
   e. Client mix and specific facilities for different age or gender groups, people with dual diagnoses, families, and chronic addictions.

2. Conduct a needs assessment of detoxification services for injection drugs with a focus on areas including:
   b. Physician involvement, monitoring and supervision, medical interventions.
   c. Referral mechanisms to treatment, outpatient services.
   d. Location and number of facilities.

3. Review the links between treatment options and other essential services for IDUs (e.g. prevention education programs, outreach services, counseling, needle exchange, injection drug user networks) and explore ways to enhance partnerships and cross-linkages.

4. Review the needs and funding opportunities for formalizing drug user groups and networks in the SHR to provide services including: needle exchange, peer-education (e.g. safer injecting methods, adverse drug interactions, overdose, HIV/AIDS, hepatitis B and C), and credible and easily accessible referral and linkage to service providers.

5. Actively engage IDUs in the planning, implementation and evaluation of strategies, policies, programs and initiatives for IDUs.
**Long-term Strategies**

1. Consider expanding intensive harm reduction information, education, and provision of materials to other sectors in addition to Public Health Services and Addictions Services (e.g. through Education, Social Services, Saskatoon Integrated Drug Unit).

2. Review the appropriateness of the current detoxification protocol for injection drugs and determine needs for enhanced physician involvement and medical interventions.

3. Enhance family-based programming options, including family in-patient treatment, family therapy, and family engagement in the treatment and recovery process.

4. Explore ways to address issues of continued exposure to at-risk social environments.

5. Explore the applicability of expanding harm reduction based treatment options as a gateway into treatment services (25) including:
   a. Detoxification facilities: Wet detoxification facility\(^3\), mattress detoxification\(^4\), home-based detoxification.
   b. Housing options: transitional, low-demand (wet), supported, permanent.
   c. Medical centre to fast track people with addiction related trauma issues (alternative to hospital emergency rooms as holding areas).
   d. Sobering up stations and diagnostic screening centers (gateway into treatment; opportunity for case managers to recruit high needs clients and connect them to existing services).
   e. Safe injection facility.

6. Support in principle, clinical trials to assess the treatment effectiveness of the prescription of heroin, buprenorphine, and other drugs.

7. Advocate for the provision of needle exchange in correctional facilities.

8. Support piloting of the drug treatment court in Regina.

**Expected Outcomes**

1. IDU clients will have a greater array of detoxification and treatment options available and accessible to them.

2. Improved client matching to appropriate services on an individualized basis.

3. Enhanced detoxification and treatment services to meet the needs of IDU clients.

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\(^3\) Detoxification facility wherein drug use is permitted.

\(^4\) Detoxification facility intended for brief emergency shelter with only a mattress to ‘sleep it off’.
**Potential Lead Agency or Partner Agencies**

- City of Saskatoon
- Community Addiction Services
- MD Ambulance
- Project Hope
- Saskatoon City Police
- Saskatoon Health Region—Emergency and Pre-hospital Services
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
- University of Saskatchewan
Recommendation T-6
Develop youth-specific treatment centers.

Background
The Saskatoon Youth Addictions Strategy (SYAS) (26) draws attention to the need for enhanced youth-specific substance abuse treatment in the SHR. According to the Strategy, current services provided in Saskatoon available to youth include:

- Community Addictions Services—Youth & Family Services.
- Larson House.
- Calder Centre.
- Ranch Ehrlo Society.
- Methadone Assisted Recovery Program (City Hospital and other providers in the community).

The SYAS supports the strategic plan of partnering for the creation of a continuum of care to facilitate the movement of youth into and between different services. The establishment of a youth detoxification and treatment centre, a community-based after-care program, and a family-focused treatment and after-care program are also recommended in the SYAS (26).

This strategic planning document identifies youth as a group with specialized needs to be addressed in each of the four pillars and throughout the recommendations provided (See Recommendation F-4: Engage Youth). Further support for the development of youth-specific treatment programming is provided by the Addley Report (27) and the recommendations from the At Risk Recommendations (12).

Research from the Vancouver Injection Drug Users Study identify youth as being at high risk for HIV and HCV infection, particularly among youth who are Aboriginal, female, involved in sex work, have a history of sexual abuse, or are engaged in daily poly-drug use (28). The study revealed that among 241 youth enrolled in the study, 25 (10%) were HIV positive and 110 (46%) were HCV positive at baseline. Within the 36-month study period, these percentages had increased to 23% and 76% respectively. The authors call for greater public health investment in prevention and intervention efforts, including youth-specific treatment facilities (28).

Limited research exploring the effectiveness of different approaches to substance abuse treatment for youth is available. Williams and Chang, however, offer a comprehensive review of adolescent substance abuse treatment outcomes and provide a summary of basic recommendations based on available evidence (29). The study evaluated 53 publications of research relevant to youth treatment for substance abuse.

The review found that there is general consensus that treatment is better than no treatment, but little research comparing different approach. The authors state that youth treatment programs generally differ in the location, intensity, duration and comprehensiveness of their approaches. Three general types of program approaches:
the “Minnesota Model”, outpatient programs and therapeutic communities (see Table 7.4).

Table 7.4: Differences between Three Common Youth Treatment Program Models

<table>
<thead>
<tr>
<th>Dimension</th>
<th>“Minnesota Model”</th>
<th>Outpatient Programs</th>
<th>Therapeutic Communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Hospital in-patient</td>
<td>Outpatient</td>
<td>Residential Settings</td>
</tr>
<tr>
<td>Where are the programs typically offered?</td>
<td>Daily Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensity</td>
<td>24-hour Supervision</td>
<td>1-2 Sessions/week</td>
<td>Day Program</td>
</tr>
<tr>
<td>How frequently is support provided?</td>
<td>Day Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration</td>
<td>4-6 weeks</td>
<td>Flexible: one session to six months</td>
<td>Varies, but typically regimented</td>
</tr>
<tr>
<td>How long do the programs usually last?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>Individual Counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What kinds of activities are usually involved?</td>
<td>Group Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medication for Co-morbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schooling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recreational Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Individual Counseling (Occasional)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Schooling</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recreational Programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitated by paraprofessionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Members progress through a hierarchy of responsibilities within a community of former users</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Among the 53 studies reviewed, several identified different variables associated with successful treatment outcomes. The authors summarize the variables related to positive outcomes, breaking them into pre, in, and post-treatment factors associated with success (Table 7.5).

Table 7.5: Variables Associated with Successful Treatment Outcomes

<table>
<thead>
<tr>
<th>Pre-Treatment</th>
<th>In-Treatment</th>
<th>Post-Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer and parental social support (particularly in their nonuse of substances)</td>
<td>Completion (most consistently related to positive outcomes)</td>
<td>Attendance in aftercare</td>
</tr>
<tr>
<td>Better school attendance and functioning pre-treatment</td>
<td>Larger programs with larger budgets</td>
<td>Having non-using parents and peers</td>
</tr>
<tr>
<td>Employment</td>
<td>Program comprehensiveness: provision of schooling, vocational counseling, recreational activities, birth control</td>
<td>Having better relapse coping skills</td>
</tr>
</tbody>
</table>
Based on the evidence available, Williams and Chang offer a series of programmatic recommendations (29). Youth treatment programs should:

- Strive to be readily accessible and able to provide treatment for large numbers of people.
- Develop ways to minimize treatment dropout and maximize treatment completion.
- Attempt to provide or arrange for post-treatment aftercare.
- Provide comprehensive services in areas other than substance abuse (e.g. schooling, psychological, vocational, recreational, medical, family, and legal support).
- Include family therapy.
- Encourage and develop parent and peer support, especially regarding nonuse of substances.

Suggested strategies for this recommendation:  

**Short-term Strategies**

1. As a working group, review the Saskatoon Youth Addictions Strategy, with a focus on the background and recommendations specific to youth addictions treatment services.

2. As a working group, coordinate with the overall strategy of partnering to build a continuum of care (See Part 3), specifically focusing on Recommendation F-2 to ensure:
   - Adequate representation of youth.
   - That ways to mitigate youth-specific concerns and challenges are built into the continuum of care.

3. Conduct an environmental scan (may include surveys or interviews with service providers, community agencies, and youth) to assess:
   - Current services, including types of programs offered and number of clients supported.
   - Inclusion of program activities or supports related to the variables associated positive treatment outcomes (as outlined in Table 7.5 above).
   - Changes in service availability related to Project Hope.
   - Gaps in services and unmet service needs for achieving comprehensive, accessible youth treatment programming.
4. Based on the environmental scan, create a proposal to submit to Project Hope and any other relevant government agencies detailing the results of the environmental scan and highlighting persisting gaps in services.

**Long-term Strategies**
1. Advocate for enhanced drug treatment services specific to youth.
2. Advocate for the establishment of a youth detoxification centre in the SHR.
3. Incorporate a youth-specific 'stream' into the continuum of care established through the Saskatoon Injection Drug Use Strategy.
4. Actively engage in efforts to reduce youth-specific barriers to treatment, such as accessibility, availability, family support, maintenance of schooling, geography, disabilities and conduct disorders, economic and custodial concerns.
5. Establish a comprehensive after-care program that incorporates family therapy, recreational activities, peer support and other diversionary and supportive activities.

**Expected Outcomes**
1. Youth treatment services expand to include detoxification and after-care programs that are comprehensive and accessible.
2. Opportunities for successful youth treatment outcomes are maximized through the establishment of a continuum of care and the incorporation of comprehensive support through after-care programs.
3. Youth engaged in injection drug use and at high risk for becoming infected with HCV, HIV or other blood-borne pathogens have consistent access to treatment services that provide support in coping with their addiction, ceasing injection drug use, and reducing the harms associated with high-risk behaviours.
Potential Lead Agency or Partner Agencies

- Calder Centre
- Community Addiction Services
- Kilburn Hall Youth Centre
- Larson House
- Physicians certified to prescribe methadone
- Project Hope
- Saskatoon Communities for Children
- Saskatoon Health Region—Mental Health and Addictions
- Saskatoon Health Region—Public Health Services
- Saskatoon Tribal Council
- White Buffalo Youth Lodge
Recommendation T-7
Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.

Background
In Canada and internationally, methadone maintenance treatment (MMT), sometimes referred to as Methadone Assisted Recovery (MAR), is the most widely used treatment strategy for opiate dependency. Potential benefits of people on MMT include (30):

- Significant reductions in daily use of narcotics, illicitly obtained opioids, and other substances such as alcohol, marijuana and cocaine.
- Reduced drug dealing and engagement in other criminal activities.
- Lower rates of incarceration.
- Reduced injection of drugs and injection related risk behaviors.
- Reduced engagement in risk behaviors associated with the transmission of HIV and STDs.

A number of studies have highlighted the health benefits of MMT including: a 4.2 fold protective effect to HIV seroconversion for clients on MMT for two or more years (31) compared to clients not on MMT; and a three fold lower death rate compared to clients not on MMT. Clients on MMT have shown substantial improvements in their general physical and mental health as well as their social functioning and employment opportunities.

In addition to the benefits experienced by clients receiving this supportive treatment, MMT offers economic benefits to society. In the United States, a study showed that for every one dollar spent on MMT, US$4-$13 is saved in health and social costs to the community (32). Similarly, a study in Toronto estimated the average social cost of an untreated illicit opioid user to be $49,000 per year, compared to the provision of MMT for approximately $6,000 per year (33).

Despite the individual and societal benefits and advantages of MMT, significant barriers to accessibility remain at the societal, systems, program and individual levels. Access issues raised by stakeholder consultation align with those identified in the literature (30):

- Philosophical differences among practitioners.
- Regulation of MMT.
- Admission criteria.
- Limited number of methadone prescribing physicians.
- Limited resources allocated to MMT.
- Lack of access in rural or remote areas.
- Lack of outreach services.
- Fear or misinformation about MMT, its effectiveness and use.
- Limited supports for clients (e.g. treatment costs, transportation, child care).
- Limited support for practitioners.

In Saskatchewan, there has been an increase in the number of physicians licensed to prescribe methadone to opiate-dependent persons from six doctors in 1997 to 17 doctors in June 2000. Consequently, the number of patients receiving methadone maintenance increased from 20 in 1996 to 550 in 2000 (Saskatchewan Health, 2000). There are currently four physicians certified to prescribe methadone and eight pharmacist dispensers in Saskatoon, which does not adequately address the service needs.

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Conduct a review of MMT services and needs in Saskatoon and explore strategies to reduce barriers and increase access to treatment. Some areas to be reviewed may include:
   - Program policies.
   - Service volumes and waiting periods.
   - Hours of operation.
   - Referral mechanisms and links to community based social supports.
   - Affordability of treatment for the client (e.g. travel costs etc).
   - Availability of other supports for the client (e.g. child care, bus passes etc.).
   - Program location and points of access.
   - Program transferability (the degree to which access to treatment is maintained when clients relocate).

**Long-term Strategies**

1. Reduce attitudinal barriers to MMT through the expansion of educational efforts to target various stakeholder groups including policy makers, practitioners, clients and the community.
2. Address the philosophical differences among practitioners through increasing education forums and facilitating opportunities for dialogue.
3. Develop education programs for physicians interested in prescribing methadone and pharmacists interested in dispensing methadone.
4. Sponsor continuing medical education workshops in addiction medicine.
5. Enhance physician recruitment initiative (medical/nurse physicians) to include educational strategies about MMT and the exploration of incentives.
6. Move to a client-centered shared care model between a primary physician certified to prescribe methadone and a secondary/tertiary physician management in the community.

7. Move from the compartmentalized provision of methadone maintenance programs to its integration into a comprehensive health care system. In line with best practices in Australia, the UK, Switzerland, the Netherlands and Germany, expand MMT to closely link with other essential services for IDUs including education programs, outreach services, counseling, needle exchange, injection drug user networks.

8. Enhance physician’s training in addictions medicine.

9. Increase the number of pharmacist methadone dispensers in the SHR.

**Expected Outcomes**

1. Methadone assisted recovery becomes more readily available and accessible to clients.

2. There is a greater awareness of MMT among medical professionals, stakeholders, clients and the community.

3. A potential reduction in risky behaviors associated with the injection of heroin and an associated potential reduction in disease transmission.

**Potential Lead Agency or Partner Agencies**

- College of Physicians and Surgeons of Saskatchewan
- Community Addiction Services
- Family Physicians
- Methadone Assisted Recovery Program—Saskatoon City Hospital
- Saskatchewan Medical Association
- Saskatchewan Pharmaceutical Association
- Saskatoon Health Region—Mental Health and Addictions
- Saskatoon Health Region—Public Health Services
- Westside Community Clinic
Recommendation T-8
Work in partnership with clients and their circle of care in a coordinated effort to plan and manage the recovery process.

Background
Continuity of care is dependent on the integration of comprehensive services tailored to meet the individual needs of clients. Research has demonstrated a correlation between high levels and intensity of ancillary services, and improved treatment outcomes (8). A holistic approach to the recovery process should provide a full spectrum of available supports and services either on-site or via effective referral and service delivery networks. These comprehensive services would include components of (30):

- Health promotion.
- Disease prevention and education.
- Substance use treatment.
- Counseling and support.
- Mental health services.
- Medical care (evaluation, monitoring, care, treatment and support).
- Outreach and advocacy services.
- Community based services and supports (e.g. social services; child, youth and family services; legal/justice system services; and education).

A continuum of service care should include intake, detoxification, stabilization, relapse prevention, rehabilitation, and intensive post-treatment and follow-up and support in the community as needed. Research has shown that when integrated comprehensive services are provided in a client-centered approach, treatment outcomes are significantly improved (8).

Stakeholder consultation revealed the current lack of a chronic disease management model for chronic IDU clients who encompass approximately 20-25% of IDU clients from Community Addictions Services. The other 75-80% of clients who use injection drugs, use it in a harmful/hazardous way and don’t necessarily need chronic management. The United Nations International Drug Control Programme released a discussion paper for policy makers that addresses this issue (34). The paper likens drug abuse treatment to treatment for chronic conditions such as diabetes and hypertension. The argument presented is that drug treatment and treatment for diabetes and hypertension are heavily dependent on client behavioral change and medication compliance to achieve optimal effectiveness.

In the treatment of substance abuse, most clients who start any type of treatment drop out prior to completion or do not comply with practitioner’s advice to remain on medicine and continue participation in after-care and self-help groups. Rates of low compliance in drug treatment is comparable to that of treatment for type-1 insulin-dependent adult diabetes and adult hypertension in which less than 60% and 40% respectively, fully
comply with their medication schedule. Moreover, studies have shown that less than 30% of diabetic and hypertensive patients in treatment, comply with prescribed diet and/or behavioral changes designed to improve their functional status and reduce risk factors for reoccurrence of the disorders. In the treatment of addictions as well as chronic disease of diabetes and hypertension, compliance to treatment and ultimately outcome is poorest among patients/clients with low socio-economic status; low family and social supports; or significant psychiatric co-morbidities.

The paper suggests that perhaps due to similarities in treatment compliance, relapse or reoccurrence rates are also similar: 40-60% relapse rate for drug treatment at one-year follow up; 30-50% reoccurrence of symptoms for insulin-dependent adult diabetes and 50-70% for adult hypertension each year to the level in which they require at least re-stabilization of their medication and/or additional medical care to re-establish remission of symptoms. Given the similarities between outcome issues surrounding drug treatment and diabetes/hypertension treatment, the authors state that it is ludicrous to follow an acute care model for diabetes/hypertension, in the way that drug treatment is programmed, and instead, drug treatment should be programmed under a chronic disease management model.

**Suggested strategies for this recommendation:**

**Short-term Strategies**

1. Conduct a review of best practices of chronic disease management models that can be applied to IDU.

2. Advocate for peer education to medical professionals, stakeholders and the community to raise awareness of chronic IDU as a chronic disease that requires lifetime management like other chronic diseases such as diabetes or cardiovascular disease.

3. Strengthen the principle of client-centered care across interdisciplinary programs and services through ways such as:
   a. Supporting outreach and proactive recruitment of potential clients through peer-based strategies, linkages and partnerships with agencies working at the front line.
   b. Encouraging and facilitating client involvement in decision making at both individual and program levels through meaningful participation in setting priorities and direction (e.g. community advisory boards, steering committees, and feedback mechanisms such as suggestion boxes, surveys, focus groups).
   c. Advocating for clients to be trained as peer counselors/advocates.
   d. Respecting clients’ dignity, choices, life circumstances and responsibilities and finding ways to reduce perceived and practical barriers to access of services.
e. Striving to be inclusive and meeting the needs of diverse client groups (e.g. people with multiple substance use behaviors, women, youth, homeless, people living in rural/remote areas, Aboriginal peoples, people living with HIV/AIDS or HCV, people living with mental health disorders, or offenders in the correctional system)

f. Tailoring treatment to meet individual client needs through fostering a collaborative, relationship-building, consultative partnership between clients and program team members at every stage of the recovery process.

**Long-term Strategies**

1. Provide resources to support peer-based advocacy groups to enable them to offer socialization outlets, advocacy, education, job finding services, or other relevant support services.

2. Develop a chronic disease management model for IDU in line with those used in the management of other chronic diseases such as diabetes and cardiovascular disease which have an emphasis on community outpatient services.

3. Develop different treatment models to meet different client needs (e.g. treatment programs for chronic IDU clients versus harmful/hazardous use clients) based on best practices.

4. Enhance family/circle of care involvement in the recovery process as well as support to the family/circle of care, based on best practices.

5. Allocate resources to assist recovering IDUs return to the workforce, enhance support groups for IDUs and their families, and enhance support programs for clients coming out of methadone maintenance programs.

**Expected Outcomes**

1. The recovery process will be individualized for each client’s unique needs depending on their level of addiction, membership in particular client groups.

**Potential Lead Agency or Partner Agencies**

- Community Addiction Services
- Métis Addictions Council of Saskatchewan
- Project Hope
- Saskatchewan Hepatitis C Clinic
- Saskatchewan Infectious Disease Clinic
- Saskatoon Health Region—Chronic Disease Management Group
- Saskatoon Health Region—Mental Health and Addictions
- Saskatoon Health Region—Public Health Services
- Saskatoon Tribal Council
**Recommendation T-9**
Recognize that cultural and spiritual experiences are integral to the recovery process for IDU clients.

**Background**
Because of the complex interaction of historical, political, social and cultural factors affecting Aboriginal people in Canada, a disproportionate burden of IDU is experienced by First Nations and Métis communities. As programs and services for IDU become more client-centred, cultural and spiritual dimensions of care may need to be incorporated into the recovery process. Currently, Saskatoon faces a lack of capacity in terms of resources or funding to specifically include Aboriginal perspectives of holistic health and healing into treatment and recovery models. PHS’s care provider survey revealed an absence of spiritual care from the inventory of supports and treatments offered by service agencies in Saskatoon (10). Furthermore, Addley recommends that treatment programs consider the specific needs and cultures of First Nations and Métis communities in their design (27).

The Centre for Substance Abuse Treatment (7) conducted research into considerations for culturally diverse clients and offer guidelines to better understand a client’s cultural framework. The SMASHA guidelines offer a series of questions exploring cultural and spiritual dimensions of clients’ (7). The questions are recommended for inclusion in any preliminary assessment or intake counseling that clients entering treatment or recovery programs may participate in (Table 7.6).

**Table 7.6: SAMSHA Guidelines for Preliminary Assessment of Clients Entering Treatment and Recovery Programs**

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What language do you prefer we use?</td>
</tr>
<tr>
<td>2</td>
<td>Therapists and clients sometimes have different ideas about diseases, can you tell me more about your idea of why you are in detoxification now?</td>
</tr>
<tr>
<td>3</td>
<td>Do you require assistance for daily living activities (such as personal hygiene, shopping, paying bills, etc.)?</td>
</tr>
<tr>
<td>4</td>
<td>What do you call your present condition/situation (as it relates to substance use)? How does your family view your present condition/situation (as it relates to substance use)?</td>
</tr>
<tr>
<td>5</td>
<td>What is the role of alcohol or drugs in your family?</td>
</tr>
<tr>
<td>6</td>
<td>How does your community view your present condition/situation (as it relates to substance use)? Or what is the role of alcohol or drugs in your community?</td>
</tr>
<tr>
<td>7</td>
<td>How has your present condition/situation (as it relates to substance use) altered your status in the community?</td>
</tr>
<tr>
<td>8</td>
<td>What experiences have you had with the healthcare system?</td>
</tr>
<tr>
<td>9</td>
<td>Do you think your substance use is a problem for you?</td>
</tr>
</tbody>
</table>
10. What do you think caused your present condition/situation (as it relates to substance use)?

11. Why do you think it started?

12. What is going on in your body?

13. How has your present condition/situation (as it relates to substance use) altered your life?

14. How have you tried to solve the problem(s) associated with substance use in the past? Was it helpful?

15. What worked/didn’t work?

16. Why are you coming now?

17. Are you on any herbal medications or special foods for this problem?

18. What concerns or fears do you have about your present condition/situation (as it relates to substance use)?

19. What concerns or fears do you have about this treatment?

Suggested strategies for this recommendation:

**Short-term Strategies**

1. Conduct a needs assessment through focus group discussions with IDUs and service agencies to determine cultural and spiritual needs and how they can be incorporated into existing treatment protocols and supports.

2. Assess cultural barriers to the access of treatment services and explore ways to facilitate improved access.

3. Review Aboriginal addiction recovery movement initiatives and Aboriginal healing and wellness strategies throughout Canada that promote community healing, development and empowerment (e.g. projects through the Aboriginal Healing Foundation).

4. Consider community development plans for the SHR.

5. Review treatment intake protocols for their cultural specificity, using SAMHSA’s guidelines as a framework.

**Long-term Strategies**

1. Advocate for funding and resources to develop components of treatment which address spiritual needs, practices and beliefs.

2. Develop educational training programs for service providers, stakeholders, policy makers and the community in cross-cultural issues related to substance abuse and treatment as well as Aboriginal principles and methods to promote healing.
3. Promote Aboriginal leadership by facilitating active participation of Aboriginal staff, consultants, elders, or peer educators in the delivery of programs or services.

4. Promote the use of traditional healing (e.g. spiritual assessments, healing ceremonies, sweat lodges) in conjunction with ‘western’ medical methods.

5. Work with First Nations and Métis organizations to establish Aboriginal community development plans and healing and wellness strategies.

**Expected Outcomes**
1. Cultural and spiritual care will be programmed into existing treatment services and be an option to enhance client’s treatment and recovery process.

2. Enhanced awareness and training amongst service providers of Aboriginal concepts and methods for healing.

**Potential Lead Agency or Partner Agencies**
- AIDS Saskatoon
- Community Addiction Services
- Persons Living with AIDS (PLWA)
- Saskatoon Health Region—Ethicist
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Tribal Council
- The Friendship Inn
- Westside Community Clinic
- White Buffalo Youth Lodge
**Recommendation T-10**
Program family involvement, support and education into the treatment and recovery process.

**Background**
Service providers participating in the PHS Care Provider Survey reflected that many IDU clients have families and are entrenched in social environments with complex addiction problems. These survey participants felt that a broader range of family treatment options was needed to more comprehensively address client needs. The survey reported a lack of support available to families of IDU clients, particularly as clients move through treatment and recovery programs (10). Although a number of agencies provide family programs (e.g. Community Addictions Services), service providers felt that accessibility in the community was reduced by stigma against IDU.

Differences exist between family-involved therapy and family therapy. The majority of targeted family programs in the SHR offer family-involved therapy—an educational approach that attempts to educate families about relationship patterns typically contributing to substance abuse problems. The focus of this type of therapy is on psycho-education about substance abuse, related behaviors, and the behavioral, medical and psychological consequences of use.

Studies have shown that treatment that includes family therapy increases client engagement and retention in treatment, reduces client drug use, reduces relapse, and improves family and social functioning (35). Family therapy programs wherein the family is the primary therapeutic grouping are less common. This approach targets interventions at facilitating changes in maladaptive interactions within the family system. It involves changing of the entire family system to make interpersonal, intrapersonal, and environmental changes with the view of subsequently affecting the family member using drugs (35). The overarching goal of this approach to family therapy is the prevention of substance abuse from moving from one generation to another.

The literature highlights the role and benefits of family involvement, support and education in the treatment and recovery process, including (36):

- Provides counseling staff with an opportunity to learn about the client’s family, observe family interaction, and obtain family members input into the recovery process.
- Facilitates compliance with treatment. Family pressure can assist with adherence to treatment services during periods when motivation is low.
- Allows family members to verbalize their concerns, questions, experiences, and feelings related to the addicted family member.
- Allows the client the opportunity to hear how the family experiences the addiction.
- Offers the client the opportunity to receive support from the family.
- Offers the family opportunities to receive education and support from other families by providing a forum to share feelings of anger, worry, confusion, and other emotional reactions and can help with diffusing strong negative feelings.
- Provides family members with opportunities to learn about and be encouraged to attend support groups such as Nar-Anon or Al-Anon.
- Highlights enabling behaviours of family members and provides support for changing such behaviours.
- Builds capacity within the family unit by offering family members strategies that can improve their coping abilities with an addicted relative.
- Builds capacity among individuals within a family by offering self-care strategies so that all the recovery efforts are not simply directed at the addicted person.
- Creates opportunities to extend treatment or recovery options to other family members who may be experiencing a psychiatric or addictive disorder by encouraging them to seek help or facilitating referrals.

Suggested strategies for this recommendation:

**Short-term Strategies**

1. Raise awareness among health professionals about the support needs of families of IDU clients to promote increased referrals through enhancing professional education courses currently run by Community Addiction Services.
2. Enhance education of front-line workers to build knowledge and skills in engaging with the family of IDU clients at early contact to bring them into the client’s circle of care as well as to provide the family with necessary supports.
3. Utilize a case management approach to actively engage family members in the client’s circle of care and to provide supports to the family.
4. Review models of family therapy (e.g. Family Disease Model, Family Systems Model, cognitive-behavioral approaches, multidimensional family therapy) and determine applicability for adoption in Saskatoon, with the realization that a “one size fits all” program is not possible and instead programs must be flexible and responsive to family needs.

**Long-term Strategies**

1. Increase the number of FTEs in addictions counseling to adequately address the diverse needs of family programs.
2. Enhance family-involved therapy and family therapy based on best practices that respond to and meet the needs of clients and their families. This includes age-appropriate educational support services for children and adolescent family members.
**Expected Outcomes**

1. Family engagement and supports to the family in the treatment and recovery process are improved.

2. Client assessment tools (particularly any common assessment frameworks developed in conjunction with the continuum of care) incorporate a family dimension.

3. Family therapy is programmed into existing treatment and recovery services.

**Potential Lead Agency or Partner Agencies**

- AIDS Saskatoon
- Alcoholics Anonymous
- Communities for Children
- Community Addictions Services
- Families Against Meth
- Family Healing Circle Lodge
- Narcotics Anonymous
- Project Hope
- Royal University Hospital & Saskatoon City Hospital—Departments of Psychiatry & Psychology
- Salvation Army
- Saskatoon Health Region—Chronic Disease Management
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Primary Health Services
- Saskatoon Health Region—Public Health Services
- Saskatoon Indian & Métis Friendship Centre
- Saskatoon Tribal Council
- Westside Community Clinic
Recommendation T-11
Address barriers to the access and availability of treatment and recovery services for IDU clients.

Background
IDU clients represent a diverse group of men and women from different age groups and with diverse cultural and socioeconomic backgrounds. They are involved in many types of relationships, family situations, and life circumstances. Clients may have concurrent physical or mental health problems and may live in urban, rural or remote areas. Individual client needs are similarly diverse and depend on these multiple determinants of health.

There is currently limited research evidence to show that specifically designed treatment interventions aimed at various groups result in increased treatment outcomes (8); however, some client groups may experience more barriers to access than other groups. For example, women, youth, homeless persons, people living in rural or remote areas, Aboriginal peoples, people living with HIV/AIDS or HCV, people living with mental health disorders, and offenders in the correctional system may have unique needs that must be addressed in order to facilitate access to treatment and recovery services. Because of the unique needs of specific groups, there has been a move towards treatment programming for special populations.

Barriers to accessing treatment services include general barriers and barriers for specific groups.

General Barriers
Personal barriers
- Social stigma and labeling leading to shame and embarrassment in accessing services (37).
- Lack of confidence in drug treatment and its effectiveness (38).
- Belief that people who use substances should be able to handle problems themselves without seeking help (38).
- Lack of information about treatment programs and resources (39).
- Lack of incorporation of Aboriginal cultural and spiritual values and meanings into the recovery process (e.g. accompaniment by a trusted person on the journey to healing, sweat lodges, healing circles). Refer to Recommendation T-9.
**Structural and program barriers**

- Lack of outreach services to support entry into treatment (40).
- Presentation at services other than addictions (i.e. entry points).
- Costs associated with treatment (e.g. direct cost of treatment, replacement of wages, treatment support costs such as child care or transportation) (41).
- Treatment based on a male model of treatment (e.g. lack of female specific program elements, limited female staffing, limited attention to women’s values and ways of interacting) (42).
- Attitudes of service providers (e.g. punitive versus therapeutic relationship).
- Misdiagnosis and lack of effective referral mechanisms (e.g. a study found that only 10% of women requiring treatment had been referred to treatment by their general practitioners, as compared to almost 50% who had been prescribed medication for nerves or menopause (8).
- Rigid abstinence requirements.
- Lack of staff continuity (43).
- Location of service setting (e.g. in stigmatizing psychiatric facility (43).
- Low morale and commitment of staff (43).
- Waiting lists (43).
- Aggregation of treatment and support services in the inner city which is difficult for people in other suburbs to access.
- Lack of treatment services outside of large cities, particularly in remote, rural communities.

**Barriers for Specific Groups**

*Women* (8)

- Lack of treatment services and resources for pregnant and parenting women (e.g. detoxification during pregnancy, perinatal issues, childcare) (44).
- Childcare concerns such as a lack of child-care services in association with treatment services; fear of children being placed in foster care while undergoing treatment.
- Greater stigma attached to women with substance abuse problems and thus more negative consequences attached to treatment entry (e.g. resistance from family and friends, anger from spouse, not fulfilling responsibilities of a wife/mother)
- May be less likely to use specialized services and instead seek general services from their GP who may not screen for substance abuse.
- Women with a multitude of problems prefer to use informal support networks.
- Employee assistance programs are less likely to identify and refer women clients.
Clients with concurrent mental health problems

- Tend to be in a pre-motivated state regarding their substance abuse and thus these issues are less likely to be revealed on standard assessments for substance abuse. Instead, substance abuse issues of these clients tend to be associated with money management and stable housing issues (45).

- Greater tendency to utilize services from the general health care system, social services and criminal justice systems, than from specialized addiction or mental health services (46).

- System level issues such as fragmentation of services, inadequate or inappropriate referrals, and lack of service coordination.

- Sequential or parallel treatment of dual substance abuse and mental disorders is not as effective as integrating mental health and addiction services and providing them simultaneously (8).

Clients living with HIV/AIDS

- A significant barrier to the utilization of substance abuse treatment services by People Living with HIV/AIDS (PLWAs) is the difficulty of dealing with these two issues together (e.g. lack of sufficient knowledge in the area of substance abuse by professionals trained in counseling PLWAs and similarly addictions professionals lack knowledge in specific issues of PLWAs) (8).

Suggested strategies for this recommendation:

**Short-term Strategies**

*For reducing general barriers to access of treatment services*

1. Coordinate with Transit and DCR to provide bus passes for clients accessing treatment services (e.g. for infectious disease appointments, community addictions services appointments. sexual health clinic appointments).

2. Coordinate with Sask Tel and DCR to install and maintain telephone services for clients.

3. Facilitate the fast-tracking of high needs complex clients to supportive services such as the Infectious Disease Clinic, methadone treatment, and Mental Health and Addiction Services.

4. Make widely known the family residential treatment services offered through Mental Health and Addiction Services.

5. Review sites and hours of operation for outreach services in light of service needs determined from the new Street Health database and other sources as determined by partner agencies.
For reducing barriers to access of treatment services for specific populations

Women

1. Research has observed that women have specific preferences with regards to treatment service options. Women are more likely to access and utilize services when the following components are incorporated into the treatment program (47). Thus, the working group should review and consider enhancing treatment programs to include the women-specific modifications and support services outlined below.

   a. Schedule treatment sessions during school hours while children are in school.

   b. Enhance outreach services connected to other community-based social support services (as women prefer outreach to inpatient services).

   c. Provide options to use self-help materials to aid recovery process.

   d. Provide services to support access to treatment such as childcare, treatment facilities that cater to family needs, and transportation.

   e. Provide of women-specific support services such as pregnancy and post partum care, sexual abuse counseling, prescription drug use counseling, parenting skills and training, assertiveness training, legal counseling, and vocational assistance.

Clients with concurrent mental health problems:

1. Review philosophies or approaches between mental health and substance abuse treatment systems (e.g. definition and interpretation of problem; interpretation of client motivation and readiness for treatment; acceptable methods of treatment and treatment modalities; staff attitudes regarding drug use during treatment; duration of treatment; staff skills, training and characteristics) (48).

2. Review mechanisms of coordination between mental health services and addiction services for the identification, assessment and treatment of clients.

3. Explore best practices models of integrated service delivery including case management between addictions and mental health agencies to improve referral and coordination of services.

4. Review agency exclusion criteria of mental health and addictions services and ensure they are kept to a minimum only in cases where a compelling knowledge-based or practical rationale can be demonstrated.

5. Provide continued professional education and training to staff of mental health and addictions services, primary health care providers, disability, and social support and criminal justice agencies in methods for assessing, referring and treating co-occurring disorders.
Clients living with HIV/AIDS

1. Review current protocol for referral of People living with HIV/AIDS (PLWAs) to treatment services and explore options to enhance facilitation particularly to methadone maintenance treatment (MMT) (49).

2. Enhance the availability of support services for PLWAs. Services include: needle exchange programs, street clinics, counseling and support, social support systems to supplement basic needs like food and clothing, and supportive housing establishments.

3. Support social marketing and educational campaigns to reduce the stigma attached to PLWAs so they will come forward to access treatment options.

4. Increase awareness of and access to informal support (e.g. self-help/ mutual aid groups and self-instructional materials).

5. Enhance case management and outreach services for high needs complex clients.

Long-term Strategies

1. Develop a range of child care options to support parents who access treatment, including the provision of childcare linked to treatment and social support services; and treatment facilities that cater to child and family needs.

2. Consider the feasibility of developing a gender specific treatment center for women with special attention to the needs of First nation’s and Métis women in abusive co-dependent relationships (identified as a major service gap in Saskatchewan by Health Canada (8)).

3. Explore best practices recommended harm reduction initiatives in correctional settings and determine its local applicability.

4. Explore the feasibility of establishing quadrant services which consider the drug culture of different quadrant areas and tailor programs and services to suit each location.

5. Explore the feasibility of establishing mobile treatment teams to provide services for rural and remote communities.

6. Advocate for clinical trials of prescription morphine, heroin and cocaine, in line with best practices internationally.

Expected Outcomes

1. Efforts will be made to reduce barriers to the access and utilization of services for general IDU clients as well as specific client groups.

2. Improved access and utilization of treatment and community-based social support services by IDU clients.
Potential Lead Agency or Partner Agencies

- AIDS Saskatoon
- City of Saskatoon
- Community Addictions Services
- Persons Living with AIDS
- Royal University Hospital & Saskatoon City Hospital—Departments of Psychiatry & Psychology
- Saskatchewan Community Services
- Saskatchewan Health
- Saskatchewan Hepatitis C Clinic
- Saskatoon Health Region—Administrative Branches
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
- Sasktel
- Westside Community Clinic
- Women’s Midlife Health Centre
Recommendation T-12
Ensure a flexible and supportive client-centered plan for follow-up in the community.

Background
The PHS Care Provider Survey and stakeholder consultation highlighted the need for post-treatment and follow up planning to transition clients into the community and to support and monitor their progress. Longer term programming and some level of community action were mentioned as being critical to stabilize and solidify the recovery and healing process. This shifts the goal of treatment beyond the completion of primary treatment or initial abstinence, to increasing in the probability of continuing recovery by reducing the relapse risk factors (50). Additionally, it requires intensive post-treatment and follow-up programming to assist the client maintain stabilization of biological, psychological, and social functioning in the community, promote a healthy lifestyle, and solidify advances made in treatment and recovery programming.

The Substance Abuse Program Office, Florida Department of Children and Families, offers guiding principles for post-treatment care (50). These guiding principles recommend incorporating the following components or actions into treatment and recovery programming:

1. Development of a compatible treatment philosophy shared across all levels and sectors of care.
2. Clear articulation of goals and objectives.
3. Establishment of motivational enhancement strategies that parallel stages of recovery.
4. Provision of follow-up care for at least one year post-discharge. Six to nine months post-discharge is considered to be the most critical period for relapse.
5. Establishment of regular, adequate contact with professional services.
6. Creation of a positive support network for clients.
7. Encouragement and support for self-help involvement.
8. Delivery of an on-going and multi-dimensional assessment process.
9. Delivery of individualized services to reduce relapse probability.
10. Facilitation of transitional management to ‘bridge the gap’ for clients during the period of transition to the community.
11. Consideration of essential support services such as housing, employment services, transportation, and childcare.
12. Provision of outreach services to engage clients who may have a tendency to drop out prematurely.
13. Implementation of community monitoring strategies (e.g. drug testing, case management, home visits, telephone calls, etc.).
Suggested strategies for this recommendation:

**Short-term Strategies**

1. Conduct a needs assessment of post-treatment and community follow-up plans, including:
   a. Discussion of potential partnerships.
   b. Potential role of the electronic common assessment framework (ECAF) in monitoring of client follow-up (Refer to recommendation T-3).
   c. Relapse plan that identifies individual client triggers and community support needs.

2. Review research-based approaches to aftercare and consider its applicability for the SHR. Two examples as a starting point are:

**Long-term Strategies**

1. Consider the development of a post-treatment and follow-up strategy that includes:
   a. Enhanced case management to address multitude of essential needs that may jeopardize the recovery process if not addressed, such as:
      i. Comprehensive support services, such as housing, employment, transportation, and childcare.
      ii. Advocacy for client in contacts with school, employment, criminal justice or other public services.
      iii. Healthcare access: medical, dental, mental health, or other healthcare services.
      iv. Management of pharmacotherapy or medications.
   b. Outreach and provision of services and support in settings most conducive to client engagement (e.g. community; home) including family support.
   c. Intensive monitoring strategies particularly for the first 6-9 months (highest relapse rate). Strategies may include drug testing, home visits, or follow-up phone calls.
   d. Linkage with self-help activities (e.g. twelve step fellowships).
   e. Linkage with senior peers with advanced recovery to provide mentorship and support.

2. Explore the potential of recruiting a designated post-treatment coordinator whose primary responsibility is to coordinate, facilitate, and follow-up post-treatment services and progress in the community.

**Expected Outcomes**

1. Post-treatment and follow-up in the community will factor as a more dominant role in the continuum of care for IDUs.
2. Improved treatment outcomes as a result of enhanced post-treatment and follow-up plans.

**Potential Lead Agency or Partner Agencies**

- CHEP
- Community Addictions Services
- QUINT
- Saskatoon Communities for Children
- Saskatoon Health Region—Mental Health & Addictions
- Saskatoon Health Region—Public Health Services
References


Appendix A: Toolbox for Action

Rapid Self-Assessment for the IDU Comprehensive Continuum of Care

This exercise is intended to provide a snapshot of the experiences, capacities, resources and learning needs of members in each of the four working groups (Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery). This tool is a brief exercise to help working groups understand the experience base, values and needs of participating members (as groups, organizations or institutions).

Table A.1: Four Pillars Defined

<table>
<thead>
<tr>
<th>Health Promotion &amp; Primary Prevention</th>
<th>Includes strategies that promote health and strive to prevent IDU. In addition to education and raising awareness, prevention efforts also include the strengthening of social, economic and health parameters, including access to stable housing, education, employment and health care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm Reduction</td>
<td>Includes strategies that reduce the harm for people who use injection drugs and that contribute to reducing drug-related harm rather than drug use.</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Includes strategies that address issues related to illegal drugs and their control such as the need for peace, public order, and safety in our homes, local neighborhoods and the entire city.</td>
</tr>
<tr>
<td>Treatment &amp; Recovery</td>
<td>Includes strategies that improve the physical, emotional and psychological health and wellbeing of current and former IDUs through various psychosocial, psychopharmacological, and spiritual or cultural healing methods.</td>
</tr>
</tbody>
</table>
Instructions
Completing this self-assessment should take no more than one hour. Remember that this is not intended to be exhaustive, but a brief overview.

1. Read the definitions of each of the four pillars provided above.
2. Think about how these pillars fit with your organization’s work and answer the questions provided.
3. Provide a response, indicating the pillar(s) you’re writing about in the response you provide.

Questions
1. Provide a brief overview of the experiences in --Health Promotion & Primary Prevention, Harm Reduction, Enforcement, or Treatment & Recovery-- that your organization has had over the last five years.
2. What skills, capacities or strengths can you offer --Health Promotion & Primary Prevention, Harm Reduction, Enforcement, or Treatment & Recovery-- in addressing or responding to the recommendations outlined in the strategic planning document?
3. Do you have personnel with specific training or specialized skills in --Health Promotion & Primary Prevention, Harm Reduction, Enforcement, or Treatment & Recovery-- that would contribute to addressing or responding to the recommendations outlined in the MOH report?
4. Please list any other resources or capacities that your organization could contribute or make available for the development of responses to the recommendations outlined in the strategic planning document.
5. Identify learning or other specific needs, hopes or expectations you have of the --Health Promotion & Primary Prevention, Harm Reduction, Enforcement, or Treatment & Recovery-- pillar.
6. In your opinion, what supports (including in time, space, and resources), assets, or experiences are you willing to contribute to the --Health Promotion & Primary Prevention, Harm Reduction, Enforcement, or Treatment & Recovery-- pillar?
First Workshop Guide

The recommendations of the Saskatoon IDU Strategy are strategically organized using the four pillars of Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery. These pillars provide a structure in which working groups can organize around to consider different series of recommendations.

Four Pillar Working Groups
The working groups are open, inclusive, dynamic and participatory. Working groups currently include representatives who identified with one of the pillar strategies during stakeholder meetings in 2005 and 2006. Membership in these working groups will expand as each pillar considers the foundational and pillar specific recommendations. As membership in the working groups expand, emphasis should be placed on the importance of active participation of Aboriginal stakeholders, communities, youth and IDUs.

This workshop guide will help working groups take the first step towards building partnership around IDU. Following sessions to introduce working groups to the Saskatoon IDU Strategy, stakeholders will be asked to read relevant components of the strategic planning document giving careful consideration to the recommendations provided.

Instructions

Before the Workshop
(Time: Reading time plus 15-30 minutes reflection)
Stakeholders preparing for the first workshop will need to take some time to review this strategic planning document.

1. Read the sections of the strategic planning document relevant to you or your organization. Part 1 (Introduction & Overview), Part 2 (Profile of IDU) and Part 3 (Integration & Planning) are relevant to all stakeholders.

2. Think about how the content and foundational recommendations and those outlined in relevant pillars provided apply to:
   a. The Saskatoon IDU Strategy
   b. You or your organization

3. On a piece of blank paper, write one to two sentences describing your initial reaction(s) to: (a) the strategy as a whole; and (b) relevant recommendations. Bring this paper with you to the workshop. It will be shared with other stakeholders in your working group(s).
**Workshop**

*(Time: 2 hours)*

*Resources Required: Space with tables and movable chairs, a facilitator, large pieces of paper, markers, and 3 cue cards (1 each of three colours) per participant*

*Purpose:* This workshop is intended to explore initial reactions to the strategic planning document and invest in the first stages of building partnership around IDU.

*Learning Objectives:* Stakeholders participating in this workshop will be able to:

1. Identify the diverse range of stakeholders who are interested in participating in the relevant pillar.
2. Understand stakeholders’ initial responses to the strategic planning document, the idea of partnership and the recommendations provided.
3. Identify some of the strengths and challenges that stakeholders see in building partnership.

**Activity 1: Greeting & Introductions (10 minutes)**
Facilitator will introduce workshop and ask for an initial round of introductions. Ask people to place the papers describing their initial reactions into a pile.

**Activity 2: Initial Reactions (20 minutes)**
Break into groups of 2-4 people. Distribute the initial reaction papers evenly among each group, asking the groups to read the reaction statements and discuss how what they’ve read compares to their own reactions.

**Activity 3: Response to Proposed Partnership (40 minutes)**
Facilitator to ask one person from each group to stand and move to the group to their right and then one person who didn’t move yet from each group to move to the group to their left.

Ask groups to discuss the proposal for building partnership around IDU (colour A), partnering for improved health for Aboriginal people (colour B) and partnering to build a continuum of care (Colour C). On one each of three cue cards, have individuals write two-three words to describe their own understandings or beliefs about why important, one challenge or one benefit. Participants should indicate what their words are referring to by writing “Why Important?”, “Challenge”, or “Benefit” at the top of the card.

Once everyone has had time to write up each of their own cards, ask them to tape the card to a corresponding large paper on three different walls that everyone can access. Invite participants to walk around the room, reading the cards that people have posted.
Activity 4: Group Discussion (20 minutes)
Return to the larger group. Facilitator will ask if there are any participants who would like to share what was discussed in the first smaller groups (initial reactions). Facilitator will ask participants to consider the papers posted at the front of the room and facilitate a discussion about the major benefits, challenges and reasons for each of the three points.

Activity 5: Planning (30 minutes)
Facilitator to assist participants to identify:
1. A date and location for the next stakeholder meeting.
2. A rough agenda for the next meeting. Working groups may consider adapting some of the activities here to discuss their individual pillar.
3. A volunteer to facilitate the next meeting.
4. Establish a contact list identifying phone number, email, organization (if applicable) of participants in the workshop.
5. Establish a list of stakeholders not present who should be invited and encouraged to participate in the next meeting.
Jordan’s Story
Jordan sinks into the outreach van’s ‘client chair’ in front of Sara, a street outreach worker with the Street Works program, one Wednesday night. Sara notices that Jordan looks thinner than last time she saw him. Two months ago, Sara and one of the public health nurses had to visit 19-year old Jordan at his cousin’s house to tell him that he’d been identified as an IDU contact of an individual who’d recently tested positive for HIV. It had been hard to find him at first and Jordan seemed to have a strong distrust of health workers. When they did find him, the visit had been difficult—the house was full of people and it looked like Jordan’s space was a corner of the living room. When Jordan’s test came back positive a week later, Sara’s heart sank. He had agreed to be tested, but seemed really anxious about what he’d do if the result came back positive. Sara and the public health nurse were too because it seemed like there was a lot of crisis and instability in Jordan’s life at the time.

Jordan starts to fiddle with his bag and brings out a couple of loose rigs to exchange.

“So, how’s it going?” Sara asks after setting him up with clean needles and a biohazard container. “It’s been a while since I saw you…we tried to find you at your cousin’s place just a couple of weeks ago, but it looked like something had happened?”

Jordan shifts around in his seat and shakes his head. “Could be a hell of a lot better,” he sighs as he looks around the van.

Sara looked at Jordan and asked, “Do you want to talk about it?”

Jordan shrugged and again fiddled with his bag. “Well my cousin’s place got burnt down,” he started a little slowly. “Ya, like three weeks ago. Nothin’s left.”

“Wow, I can’t believe that,” Sara said with surprise, “so, what have you been doing? Was anyone hurt in the fire?”

Jordan shook his head, “Na, just destroyed everything. No one was home.” He shifted in his seat, “So then I had no where to go and had to crash on the couch at my cousin’s friends’ place—which isn’t cool cuz they all share their rigs there and shit. I told them I didn’t do that, but I don’t know man…there were just too many people there.”

“And so this friend’s place was way down in Confed, and it was hard to get anywhere from there.” His expression turned to frustration, “and then they freakin’ cut me off of the methadone cuz I missed, like, two appointments…but it was just cuz I couldn’t get there and all my shit got burnt in the fire. How am I supposed to let them know—I can’t call ’em—I don’t got a phone!”

Sara asked Jordan about the methadone clinic he was going to. “I was tryin it out at the 8th Street Program, but it didn’t go too good cuz I couldn’t get there,” he responded.
Sara listened as Jordan continued, “and then my address is changing, right, so my assistance is kind of not coming and then I’ve got nothin’ to pay for things...so those guys at the ID clinic weren’t real happy with me either cuz I couldn’t get there in the morning. They always want me to come in the morning. It’s crap because I’m sick in the morning and I can’t get goin’ and then they say they can’t get ahold a’ me and I’m, like, no shit man cuz my house got burnt down and I got no phone!”

Jordan started to rub at his face as he continued, “So, I’m feelin’ real tired and I was doin’ OK with the methadone, but now that stuff’s screwed up and my face is all sore...somethin’s goin’ on with these teeth and I can’t even do nothin’ about that cuz none of them dentists will see me with my assistance coverage. I can’t hardly eat. I don’t know if it’s this damn HIV or my diabetes, but I feel like shit all the time now. Maybe cuz I’m not eating...maybe it’s just my life,” Jordan sighs and shrugs again. “Maybe this is just all I get for livin’ like this.”

**Ashley’s Story**

Steve and Carol seamlessly pull the gurney out of the back of their ambulance. It’s the fifth call of their shift and it’s only half-way through. Five minutes ago, they were dispatched to a call for a woman who was reported to be lying on the sidewalk and bleeding.

As they were on their way over to the call, Steve had commented that it seems like their getting a lot of calls from the same area in the last two weeks. Carol had agreed and wondered if it had something to do with the changing weather, maybe more people were out now that it was warmer. Regardless, both paramedics had noticed a substantial increase in the number of calls for violence-related injuries in a couple of scattered neighborhoods throughout the city. And both felt a little uneasy about the increase in violence, knowing that they too were vulnerable to attacks prompting the 911-calls they respond to.

No one is around as they walk up to a pile of hair, limbs and blood at the side of the street—they could see the woman was breathing and heard a few muffled moans. “Mam, my name is Carol and this is Steve. We’re paramedics and are here to help you. Try to stay as still as you can and don’t move. Can you tell me your name?”

The woman is lying on her side. Her hair and clothes are covered in blood. “Ashley,” she manages to say.

Carol and Steve complete a rapid assessment of her injuries and carefully move Ashley onto a backboard for transport to the nearest hospital. Steve notices two used, uncapped syringes lying on the ground very near to Ashley. One is very close to Ashley’s exposed leg. Steve makes a mental note to include the potential biohazard exposure in his ambulance report.

Ashley appears to have injuries to her left arm, a blow to her head that is still bleeding slowly, and several contusions to her abdomen, legs and chest. As
Carol monitors Ashley in the back of the ambulance, she asks, “So, can you tell me what happened?”

Looking at Carol carefully for any sign of reaction or judgment, Ashley tells Carol that she was working the street when some guy came at her with an iron rod. She said she didn’t know the guy and he didn’t ask her for anything, just started hitting her with the rod. She can’t remember how many times he hit her. She can’t remember anything from after he started hitting her. “Do you think he hurt my baby?” she asks Carol, “I’m in my second month.”

While Ashley talks, Carol attempts to start an IV in the non-injured arm. Carol notices track marks and asks Ashley if she ‘uses’. Ashley says, “Yes…but don’t tell the nurses, OK? They treat me bad in there.” After three attempts, Carol gets an IV going just as they pull into the ambulance bay. The two paramedics roll Ashley into the emergency department and give a quick report to the triage nurse. Ashley is sent to the trauma pod for assessment.

Ashley is told that she has two fractures in her arm, a concussion and several broken ribs. After what seems like hours and hundreds of unknown faces, Ashley cries out in anger and pain. “Can’t I get anything for this!”

A nurse at the bedside responds, saying, “We don’t support addictive habits in the ER. You’ve been given adequate medication for pain through your IV. Besides, you’re pregnant and shouldn’t be asking for anything more anyways”. The nurse walks away.

Ashley screams at the nurse, arguing “How the hell do you know what adequate medication is for me?”

Three hours later, Ashley is distraught, agitated and continues to be in pain. Her nurse is equally distraught, though his source of agitation is from the growing line of paramedics waiting for beds. After some discussion with the medical team, and under pressure to clear out some beds, it is decided that Ashley can be discharged with a request that she return in the morning for follow-up.

It’s 3:00 a.m. Ashley is sent out of the emergency department with a couple of tylenol-3’s, some loaner clothing that doesn’t fit, and a note saying she should return in the morning. She walks out the doors, head and arm throbbing in pain, and looks at the note in her hand. She crumples it up and throws it on the ground. “As if I’d come back here by choice,” she cries as tears pour down her face. She folds the over-sized sweater around her arms for warmth and walks off aimlessly. “Where the hell am I supposed to go from here?” she wonders. Her home is 15 kilometers away.
Mapping Exercise

The recommendations of the Saskatoon IDU Strategy are strategically organized using the four pillars of Health Promotion & Primary Prevention, Harm Reduction, Enforcement, and Treatment & Recovery. These pillars provide a structure in which working groups can organize around to consider different series of recommendations.

Four Pillar Working Groups
The working groups are open, inclusive, dynamic and participatory. Working groups currently include representatives who identified with one of the pillar strategies during stakeholder meetings in 2005 and 2006. Membership in these working groups will expand as each pillar considers the foundational and pillar specific recommendations. As membership in the working groups expand, emphasis should be placed on the importance of active participation of Aboriginal stakeholders, communities, youth and IDUs.

This mapping exercise will help working groups explore the proposed continuum of care and find ways in which their particular role or needs fit within it.

Instructions
Before the Exercise
(Time: Reading time plus 15-30 minutes reflection)
1. Read the two case studies provided in the Toolbox for Action.
2. Review the model proposed for the continuum of care and the additional models attached here.
3. Review the Foundational Recommendations.

Mapping out the Continuum of Care
(Time: 2 hours)

Resources Required: Space with tables and movable chairs, a facilitator, copies of the Conceptual Model for a Continuum of care and the two original conceptual models attached here, copies of Part 3 (Integration & Planning) of the strategic planning document, and copies of the two case studies.

Purpose: This exercise is intended to examine the proposed model for a continuum of care using case studies and the experience of stakeholders to understand it’s strengths, usefulness and potential areas that may need to be adapted or improved.

Activity 1: Reading the case studies (10-15 minutes)
Provide participants with an opportunity to individually read the case studies. If time is limited, one case study may be sufficient to discuss as a group. If the group is of 10 or more, divide into two groups—one for each case study.
Activity 2: Mapping Exercise (60-90 minutes)
Using the Conceptual Framework or the original conceptual models attached here, discuss as a group:

1. What happened to the individual in the case study? Where did services or communication break down?

2. Place slashes on the conceptual framework to identify points that continuity did not exist for the individual in the case study.

3. How would the continuum of care change the outcome for the individual in the case study?

4. At what point would (or could) the individual enter the proposed continuum of care?

5. Map out their movement within the continuum, paying attention to the slashes to identify service gaps or communication breakdown.

If time allows, consider discussing these questions as well.

6. How would the individual move between pillars? Between services?

7. Ideally, what resources or re-orientation of services are needed to facilitate creating this continuum of care?
Does Your Client / Patient have other service needs?
Start Common Assessment Forms
Get Consent for Referral and information Sharing

CARE PATHWAYS

IDUs with complex needs
IDUs, Youth, Children and Adults with no identified needs
IDUs with identified needs

Integrated Services from Statutory Providers or Specialists
Integrated Service Model in Outreach teams or Office panels
Single Practitioner or Service at a time

The relevant practitioner or service will take on lead professional functions
Practioner or service is already required by statute or best practice to take on the lead role e.g., client in corrections or in-patient addiction care

Integrated Services from Statutory Providers or Specialists
Integrated Service Model in Outreach teams or Office panels
Single Practitioner or Service at a time

The relevant practitioner or service will take on lead professional functions
Practioner or service is already required by statute or best practice to take on the lead role e.g., client in corrections or in-patient addiction care

Ongoing Community Education on Drugs and addiction
Targeted Services

Services will be provided as is the norm no lead practitioner or service is required

Information Sharing Between Practitioners and Services

Original Conceptual Framework—Pathways of Care (For Use with Case Studies)
From: The IDU Continuum of Care—Making it happen: Working together for injection drug users and their families (October, 2006)
Points of Entry into Supportive Services—Pathways of Care (For Use with Case Studies)

*From Injection Drug Use in Saskatoon: Building a continuum of care (2005)*
Selected Resources

The following resources provide valuable information for stakeholders as they consider the recommendations in this strategic planning document. Follow the link provided to access any of the resources here.

Partnership Assessment

- Assessing Strategic Partnership: The partnership assessment tool
  http://www.nuffield.leeds.ac.uk/downloads/pat.pdf

Partnering for Improved Health for Aboriginal People

- Foundations of a Good Practices Approach—For Aboriginal Organizations in Canada; Integration of STI prevention education with HIV/AIDS and addictions programs

- Situational Analysis: A background paper on HIV/AIDS & Aboriginal people

Other Four-pillar Strategies

- Preventing Harm from Psychoactive Substance Use—City of Vancouver Drug Policy Program

- Toronto Drug Strategy

- Central Okanagan Framework

Participatory Development of Harm Reduction Definition

- CAMH and Harm Reduction: A background paper on its meaning and applications for substance use issues
  http://www.camh.net/Public_policy/Public_policy_papers/harmreductionbackground.html

National and Provincial Strategies

- Reducing the Harm Associated with Injection Drug Use in Canada

- Healthy Choices in a Healthy Community: A report on substance abuse, prevention and treatment services in Saskatchewan
Appendix B

Linking Recommendations to Strategic Goals

The recommendations provided in this strategic plan are founded in the underlying focus of the primary goals and guiding principles. The strategy focuses on leadership and coordination, awareness, education and training, and research and evaluation. The target populations for this strategy include IDUs, communities, and children, youth and families. The strategy considers how each recommendation contributes to concrete system or program areas and target populations. Table 1.3 cross-references each recommendation with the main goal it contributes to and its organizational pillar.

Table 1.3 Recommendations of the Saskatoon IDU Strategy: Cross-referenced by Goal and Pillar

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Four Pillars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership and Coordination</strong></td>
<td>P H T E</td>
</tr>
<tr>
<td><em>Strengthen leadership and collaborative partnerships to facilitate comprehensive, coordinated and client-focused service delivery.</em></td>
<td></td>
</tr>
<tr>
<td>F-1 Improve coordination and communication between agencies and nominate lead for facilitating overall coordination of the strategy.</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>F-2 Collaborate across each of the four pillars to ensure a comprehensive and individualized approach that addresses a broad range of client and community needs.</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>F-5 Incorporate culturally relevant dimensions into strategic planning and programming aimed at improving the health and well-being of Aboriginal communities, including spiritual and traditional practices.</td>
<td>● ● ● ●</td>
</tr>
<tr>
<td>T-2 Develop a centralized, 24-hour manned depot to provide treatment options and referrals, drug-related information and assistance.</td>
<td>●</td>
</tr>
<tr>
<td>T-3 Collaborate to improve information sharing and coordination of treatment services for injection drug users.</td>
<td>●</td>
</tr>
<tr>
<td><strong>Awareness, Education and Training</strong></td>
<td></td>
</tr>
<tr>
<td><em>Increase the knowledge, skills and attitudes of IDUs, service providers, and the community in order to promote more appropriate and effective provision of and access to services.</em></td>
<td></td>
</tr>
<tr>
<td>P-2 Develop a social marketing campaign to reduce stigmatization and discrimination of people living with HIV/AIDS and injection drug users.</td>
<td>● ●</td>
</tr>
</tbody>
</table>
### Recommendations

<table>
<thead>
<tr>
<th>Four Pillars</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>●</td>
<td>Core pillar for recommendation □ Potential supporting pillar</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>P</th>
<th>H</th>
<th>T</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-1</td>
<td>Develop a clear definition of harm reduction and incorporate philosophy into each service provider’s policy of practice.</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>H-2</td>
<td>Develop an intensive education program about harm reduction that is tailored for IDUs, the community and service providers.</td>
<td>□ ● □ □</td>
<td></td>
</tr>
<tr>
<td>T-1</td>
<td>Understand and reflect in treatment the principle that drug addiction is first and foremost a health and social issue.</td>
<td>□ □ ●</td>
<td></td>
</tr>
<tr>
<td>T-7</td>
<td>Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.</td>
<td>● □</td>
<td></td>
</tr>
<tr>
<td>T-9</td>
<td>Recognize that cultural and spiritual experiences are integral to the recovery process.</td>
<td>●</td>
<td></td>
</tr>
</tbody>
</table>

### Neighborhoods and Communities

*Enhance the community’s responsibility in addressing IDU related issues as well as efforts to restore public order in the community.*

<table>
<thead>
<tr>
<th>P</th>
<th>H</th>
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</thead>
<tbody>
<tr>
<td>P-1</td>
<td>Strengthen programs which address the major social determinants leading to injection drug use.</td>
<td>● □ □ □</td>
<td></td>
</tr>
<tr>
<td>E-1</td>
<td>Adopt a holistic approach that recognizes the social determinants underlying addictions and drug-related crime.</td>
<td>□ □ □ ●</td>
<td></td>
</tr>
<tr>
<td>E-2</td>
<td>Advocate for drug addiction to be re-positioned as a health issue, with the creation of a separate drug court.</td>
<td>□ ●</td>
<td></td>
</tr>
<tr>
<td>E-4</td>
<td>Consider advocating for laws that decriminalize the possession of drugs for personal use.</td>
<td>□ ●</td>
<td></td>
</tr>
<tr>
<td>E-5</td>
<td>Advocate for enforcement efforts in policing and through the criminal justice system to be focused on supply reduction.</td>
<td>□ □ □ ●</td>
<td></td>
</tr>
</tbody>
</table>

### Children, Youth and Families

*Empower children, youth and families to adequately manage the spectrum of IDU issues, from the prevention of initial drug use to addictions treatment.*

<table>
<thead>
<tr>
<th>F</th>
<th>P</th>
<th>H</th>
<th>T</th>
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</tr>
</thead>
<tbody>
<tr>
<td>F-4</td>
<td>Engage youth in the planning, developing and implementation of all programs aimed at children and youth.</td>
<td>● ● ● ●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-3</td>
<td>Develop school-based prevention program from kindergarten to grade 12.</td>
<td>● □ □ □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-4</td>
<td>Enhance skill and esteem building programs for families.</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-5</td>
<td>Enhance positive community-based prevention programs for at-risk youth.</td>
<td>● □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T-6</td>
<td>Develop youth-specific treatment centres and program family involvement, support and education into the treatment and recovery process.</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-3</td>
<td>Advocate for the use of diversionary programs and alternative sentencing for youth charged with a drug-related offence.</td>
<td>□ ●</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Recommendations

<table>
<thead>
<tr>
<th></th>
<th>Core pillar for recommendation</th>
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<tbody>
<tr>
<td>P</td>
<td>H</td>
<td>T</td>
</tr>
</tbody>
</table>

### Injection Drug Users

*Improve the availability, accessibility, flexibility and appropriateness of service options for IDUs.*

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
<th>Four Pillars</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-3</td>
<td>Engage clients in the planning, development and implementation of all programs aimed at IDU.</td>
<td>P H T E</td>
</tr>
<tr>
<td>H-3</td>
<td>Expand outreach services through existing organizations.</td>
<td>P H T</td>
</tr>
<tr>
<td>H-4</td>
<td>Advocate for increased community-based access to harm reduction services.</td>
<td>P H T</td>
</tr>
<tr>
<td>H-5</td>
<td>Continue Needle Safe Saskatoon partnership.</td>
<td>P H T</td>
</tr>
<tr>
<td>H-6</td>
<td>Expand harm reduction strategies beyond needle exchange to include the provision of a full range of injection drug equipment.</td>
<td>P H T</td>
</tr>
<tr>
<td>T-4</td>
<td>Ensure that progression from detoxification to treatment services is timely and responsive to individual client needs.</td>
<td>P H T</td>
</tr>
<tr>
<td>T-5</td>
<td>Advocate for the treatment and detoxification services that are tailored for injection drug users.</td>
<td>P H T</td>
</tr>
<tr>
<td>T-7</td>
<td>Increase the number of physicians certified to prescribe methadone in the community as well as access to methadone treatment.</td>
<td>P H T</td>
</tr>
<tr>
<td>T-8</td>
<td>Work in partnership with clients and their circle of care in a coordinated effort to plan and manage the recovery process.</td>
<td>P H</td>
</tr>
<tr>
<td>T-10</td>
<td>Address barriers to the access and availability of treatment for IDU clients.</td>
<td>P H T</td>
</tr>
<tr>
<td>T-11</td>
<td>Ensure a flexible and supportive client-centred plan for follow-up in the community.</td>
<td>P H T</td>
</tr>
</tbody>
</table>

### Research and Evaluation

*Employ evidence-based research to guide the planning and implementation of the strategy, including the development of outcome indicators for monitoring and evaluation.*

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>F-5</td>
<td>Develop a collaborative program of action-research for the Saskatoon IDU Strategy that facilitates the engagement of stakeholders in the process of developing best practices, monitoring and evaluating initiatives, and establishing effective working groups under each pillar.</td>
<td>P H T E</td>
</tr>
<tr>
<td>H-7</td>
<td>Pending successful evaluation of <em>Insite</em> (Can'a's first safe injection site) and federal approval for expansion of similar programs, consider a safe injection site for Saskatoon.</td>
<td>P H T E</td>
</tr>
</tbody>
</table>